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District Nursing

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Editorial

WE regret the long delay, caused by the printing strike, in our appearance. We ask the indulgence of our advertisers whose announcements did not appear on time; with our apologies to readers goes the assurance that all subscriptions will be extended by one month.

In the district nursing world one of the most important developments which should not be allowed to pass without comment, was the publication of the advisory committee's report on district nurse training. More and more responsibility is being placed on the district nurse as the trend away from hospital towards domiciliary care at home gains ground. Never has specialised training been so important. The Minister has accepted recommendations for the formation of a Panel of Assessors to advise on schemes of training, and also on the final assessment of the examinations, and is circularising local authorities asking them to submit their schemes for approval, **unless they participate in schemes under the auspices of the Queen's Institute or the Ranyard Nurses, when application for approval would be made by those bodies.**

Proper staffing will mean that district nurses can do more for their patients. They can make more visits, and pay more attention to general nursing. But although nursing is the primary reason for her existence, the community looks for far more in the district nurse.

She must not only be able to adapt the principles of nursing learned in hospital, to the conditions of varying types of homes. She is a member of a team that is the basis of social and medical work in the community.

The duty of a nurse in hospital is to her hospital. The district nurse has responsibilities towards the general public, the local health authority, the hospital, and the general practitioner. She is concerned not only with nursing her patients, but with seeing that they obtain whatever they may need from the appropriate social service.

To serve her patients properly a district nurse should have specialised training. That has always been the view of the Queen's Institute of District Nursing. The implementation of the report will undoubtedly do much to make universal the status and dignity that the Institute has always sought to maintain in district nursing.

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The second paper given at an Institute conference on District Nurse Training Today and Tomorrow

What the Community Expects of the District Nurse

by RONALD W. ELLIOTT, M.D., M.Sc., D.P.H.
County Medical Officer, West Riding of Yorkshire

THE district nurse by reason of her appointment has loyalties and duties towards three branches of the health service—local health authorities, general practitioners and hospitals—as well as to the general public. This places her in a unique position and adds to her difficulties as compared with her sisters in the hospital service, but in compensation she has the satisfaction of joining in a much wider field of activities. This has considerable attraction and should give her the feeling of belonging to a team.

The idea of team work is the whole basis of social and medical work in the community, and no nurse should feel with the present set-up that she is working in isolation. Before determining what should be expected of the modern district nurse we must consider certain developments which have taken place within the last few years.

First of all there has been a steady increase in the number of staff employed as district nurses, and although some areas may not be fully served many authorities have full establishments. In an area I know well, only eight years ago we were employing unqualified people as district nurses. Increased staffing has led to a more happy and contented staff with lower case loads. There is a vicious circle of high case loads—dissatisfaction at insufficient time to spend on patients—diminution of staff. In most areas this vicious circle has been broken to the greater satisfaction of all concerned.

Although for a number of years visits for injection therapy mounted rapidly this work has recently fallen off. More visits can now be paid to patients and more attention given to general nursing. On the other hand there is a tendency for a less rapid turn over of cases, largely in the old age group, which may take up to 75 or 80 per cent of the nurses' time. This is also seen in the gradual accumulation of cases month by month and year by year of this type of case.

To counteract this, however, another tendency in recent years has become apparent. We are all aware that the general trend of thought as illustrated in several recent official reports is away from the treatment of cases in hospital and towards a greater degree of domiciliary care. A quicker turn round from hospital or even non-admission of some cases to hospital is becoming prevalent. For example, fewer cases of tuberculosis and infectious disease are admitted to hospital. More children are nursed in their own homes, and some areas have excellent schemes for this. Even a quicker turn round of maternity cases in hospital may have its effect on district nurses, particularly in infectious cases. This means that greater skills than ever need to be acquired or maintained by the district nurse under this new régime.

Against this background then, what do I expect of the district nurse as a medical officer of health? First and foremost I expect her to be a member of the whole public health team, and this can best be obtained by making certain that she has the opportunity of working with her other colleagues in the health department. In this respect there is every advantage in having, where at all possible, the district nursing headquarters situated in or near the health department, where day to day or even minute to minute contact can be made smoothly with other members of the team.

A few years ago I was very apprehensive when my authority closed down a long established district nurses' home and transferred the headquarters to the health department on a non-residential basis. At that time this was revolutionary, but I was delighted at the success. No longer was there isolation on the part of the district nurse and the service in general prospered. There is much to be said for all sections of a health department being under one roof and the medical officer of health who has this great advantage is extremely lucky.

Eyes and Ears of the Health Department

Unfortunately this is not possible in many cases for reasons of either geography or finance, and in these places it is more necessary than ever to engender the team spirit in everyone concerned. In extreme cases of isolation the district nurse may not even know her health visitor, let alone the many other social workers in the welfare and children's departments and other statutory or voluntary agencies. Apart from this essential of knowing one's colleagues in every sphere of medical and social work, it is imperative to know what else the local authority has to offer and to be able to obtain it for patients. This applies too, to the assistance which can be obtained from other auxiliary services, such as the National Assistance Board, and Women's Voluntary Service. This team work has the added advantage for the local health department, if carried out correctly, of the district nurse acting as the eyes and ears of the health department, bringing her problems and observations to the department, which would know of nothing untoward without this sort of assistance.

In turn the local health authority has its obligations to the nurse in return for what she can give. I know how difficult it can be sometimes to persuade authorities to be generous in fulfilling these obligations. First and

foremost an adequate supply of nursing equipment of all kinds must be very readily available to the nurse at all times. It goes without saying that this equipment, besides adding to the comfort of the patient, cuts down the strain and time taken in nursing. I think that most authorities now have decided that although a charge can be made for this equipment it is scarcely worth the trouble and expense of collecting, thus removing the last obstacle which could stand in the way of adequate nursing.

Doubling Nurse-power

There is then the question of transport, a very sore point with many authorities, not only for the health visitor but for all grades of staff. It is false economy not to supply a nurse with adequate means of transport. In order to persuade a reluctant authority to this end a few years ago I had observations made on the working efficiency of district nurses running a district on the one hand either by public transport, bicycle or on foot as compared with the same district run on the following day by motor transport. The results were startling. In the latter case the nurses in every instance were able to carry out twice as much work.

The local authorities must also make sure that the nurses use their professional time to the full. We must no longer return to the days when out of sheer kind-heartedness the nurse would do all kinds of things, which should not come within her sphere, such as housework, laundry, or even shopping. Adequate home help must be provided. District nursing must be maintained as an attractive profession.

What of the general practitioner, what does he expect? Like the medical officer of health he expects loyalty. This need not be an embarrassment for the district nurse. Her loyalty to the general practitioner is a clinical one, her loyalty to the medical officer of health is largely an administrative one. There is no doubt that since the National Health Service Act came into being the family doctor has moved nearer and nearer to the sphere of local health services and somewhat away from hospitals. The district nurse and the midwife have a great advantage here. For many years the family doctor and nurse have worked together. Even in areas where still a family doctor may not know of the existence of the health visitor he does know and welcomes the attention of the district nurse for his patient.

In my experience the general practitioner very rarely complains about the work of the district nurse. All he asks for are the simple necessities of loyalty, respect and courtesy (which of course he must also give in return); to be kept informed of what is happening to his patient and to be sure that his instructions are being carried out, whether this be during the day or in the late evening. Get to know your general practitioner—he is, by and large, one of your most enthusiastic supporters, providing that your personalities are such that you can get on with each other.

I see no reason why the district nurse should not work with the general practitioner in his own surgery, providing sufficient cases are handled at any one time to warrant her attendance. This can cut down the time of visiting considerably. Indeed the ambulant patient may even be induced to attend special injection sessions at health department premises, which would also cut down visiting time.

With regard to the hospital service, more liaison will be required between district nursing services and hospitals in future, in view of the trend towards more home care for the sick. The relationship here must be one of improved liaison. If the district nurse is to be asked, probably at short notice, to take on the care of a sick patient, she must be very swiftly given information as to the patient's requirements, by the hospital authorities either directly or through the family doctor. This must not be a one way liaison, and at least some consideration must be given to the convenience and available time of the district nurse before being asked to do an emergency piece of work, for example a preparational treatment before X-ray, which may completely disrupt the whole programme for a day.

As with some other services which have considerable hospital usage, may it not be a good idea to have, where the volume of work warrants it, a public health nursing liaison officer in the hospital? I have found it a great advantage with the ambulance service.

There is one way in which a hospital can be a very considerable help in return and that is in connection with the laundering of foul linen of incontinent patients nursed at home. This can be a positive nightmare for the relatives. Hospitals are fully equipped for dealing with this and it is an easy matter where there is goodwill and co-operation on all sides, to arrange a system for the collection and delivery of this linen by health departments after laundering in the hospital. This is not the type of work which local authority laundries can normally undertake. It is a direct advantage to the hospital too in that it assists in keeping some incontinent patient from occupying a hospital bed unnecessarily.

Human Understanding

In reply to the question as to what the general public expects of the district nurse, I would say that it requires to be handled with kindness, gentleness and human understanding. The right attitude to the patient is essential in the engendering of a sense of confidence in one who understands the physical need of the patient and who is able to teach him to become self reliant. I do not wish to dismiss the need of the general public too lightly and I have purposely left it to the last, because I feel that if all the other needs which I have already mentioned are met, with the addition of a little human understanding the needs of the general public will be automatically satisfied.

In return the general public have a duty to the nurse, and particularly their representatives on welfare

committees and housing committees. They should be prepared where necessary to offer housing accommodation for what is an essential service. They might also agree, as many of them have done, to the adaptation of Council property for the needs of disabled persons in the shape of equipment—hoists, lifting poles, handles on baths, extra wide doors, ramps—which make the nursing and life of the patient much simpler. Taking this thing further I would like to see housing authorities giving accommodation more often to district nurses in or near hostels or bungalows built for older people.

Finally, the district nurse has a duty to herself, which indirectly is a duty to the community, in maintaining her health. Tragic are the cases where the district nurse has had to retire from her profession because of her neglect to protect herself from sensitisation to antibiotics which she may gain very rapidly in the course of her duties unless she is constantly on the watch.

There is a status and dignity in the profession of district nurse which has been maintained for many years by such institutions as Queen's, and I wonder personally whether in view of this and the modern staffing situation local authorities will need to go ahead and arrange their own training scheme.

IN reply to questions, **Dr. Elliott** said that the reason more babies were being born in hospitals or institutions than at home was due to popular demand and had little connection with medical needs. He had worked in an area with almost unlimited maternity accommodation, where the ultimate demand was about 85 per cent. 15 per cent of women would not go into hospital under any circumstances, even for an abnormal pregnancy.

Dr. Elliott felt the percentage of institutional confinements was too high. There would always be a place for domiciliary confinements, not only because some women preferred it but also because with the present conditions in institutions, there was an element of danger from cross-infection.

Mr. A. H. Hoad (Brighton) referred to the Mental Health Bill recommended by the Royal Commission, under which more mentally ill persons would be nursed at home. He asked what part the district nurse would play in looking after these patients.

Dr. Elliott said: "The tendency of the modern outlook for mental health is for people with mental illness to be treated in as near as possible the way people are treated for physical illness. If that is to apply in hospitals and we admit mentally ill cases to medical hospitals (in other words, if designation of hospitals is to go and if we teach the public to look upon mentally ill people in the same way as physically ill people), surely our domiciliary treatment should follow suit."

He thought the district nurse would not play a very large part in nursing the mentally ill. The future tendency would be for an acutely mentally ill person to go into hospital for treatment, after which it would be the duty of the local authority to rehabilitate him into the community. This was somewhat different from the purely practical work of the district nurse, although she would probably be a member of the local authority team.

Miss D. M. Williams (Plymouth) commented on Dr. Elliott's indication of a lower turnover of patients, especially old people, with the district nurse looking after them for longer periods.

"In my own experience we get them off the books nowadays, because we rehabilitate them. We no longer keep our visits on until they die. We may be called in again later. With our rehabilitation we tend to make them cared for in their families at home, and not to need our services."

Referring to the place of the district nurse in the doctor's surgery, Miss Williams said the district nurse must not forget that many medical conditions were due to social conditions at home, and she must know about these conditions. She must visit the home to see why the patient was in the doctor's surgery at all.

First Year in Dar es Salaam

THE district nurses in Dar es Salaam paid 4073 visits during the year 1958/9. They attended 412 patients, drawn from fifteen different communities *viz:*

African 112, Arab 1, Bohoro 15, British 147, Dutch 4, Greek 16, German 5, Goan 8, Hindu 25, Ithnaasheri 17, Italian 2, Ismaili 36, Parsee 3, Polish 3, Sunni 18. Of these patients 313 had been discharged convalescent and 31 remained on the books on 1st May. Approximately 32 per cent of the patients were attended free of charge.

These figures are given in the first annual report of the Dar es Salaam District Nursing Service by the superintendent, Miss Amy Large. The cases are made up as follows: medical and diabetic 205, surgical 107, infectious diseases 9, tuberculosis 7, post natal 18, gynaecological 12, children under five 54. The Service does not undertake midwifery, although the nurses attend mothers, some of whom are discharged from hospital after 48 hours. Follow-up visits are then paid at weekly or monthly intervals to reassure the mother and give advice on infant feeding. Cases were referred to the service by private practitioners (181), hospitals (62), and clinics (81). Eighty-eight patients applied direct.

During the year, membership has increased to 673, from seventeen different communities. In order to become self-supporting the Service is aiming at a membership of 3,000. Various communities have recently promised sufficient funds to enable it to operate for a further two years, by which time it is hoped the finances will be on a sound footing.

Tribute is paid to the work of Miss Large, the superintendent, in pioneering the Service. Miss Large returned to Great Britain in July, and her place has been taken by Miss Charlotte Kratz, S.R.N., S.C.M., Q.N. & H.V. Certs, who for the last sixteen months has served on the headquarters staff of the Queen's Institute of District Nursing. Before that Miss Kratz worked as a district nurse/midwife/health visitor in Berkshire.

From the book "A Hundred Years of District Nursing" to be published later in the year by Allen & Unwin at 18s.

The 'Dark and Haymarkety' Side of Human Life

by MARY STOCKS, B.Sc.

As earlier pioneers of district nursing had found, Bloomsbury was a convenient location for an enterprise such as the Metropolitan and National Nursing Association. In the eighteen-seventies and indeed well on into the twentieth century, it was a quiet middle-class residential neighbourhood of Georgian terraces and squares. But as a centre for district nursing, it had an advantage additional to its peaceful respectability. Immediately to the south of it lay the unspeakably degraded area of St. Giles; immediately to the north of it, the slums of St. Pancras. Both provided rich fields for the exercise of district nursing under the most discouraging conditions.

No. 23 Bloomsbury Square provided an office for the secretary, as well as residential accommodation for five trained nurses and the superintendent general. The nurses had separate rooms, the superintendent general, a sitting room and two bedrooms. A dormitory with separate cubicles provided room for five "nurse candidates or probationers." Two servants constituted the domestic staff.

In East London, Mrs. Du Ane continued to operate the old non-resident system as district superintendent under the new dispensation. But her nursing standards were a continuing source of distress to the superintendent general, whose strictures were doubtless a continuing source of distress to Mrs. Du Ane. After two visits of inspection Miss Lees "found it impossible to enumerate all the hopelessly neglected cases" under Mrs. Du Ane's superintendence. Indeed the East London nurses seemed to her "nothing more than district visitors or mission women, nor was it possible for any district superintendent to exercise proper control over them unless living in the same house."

A resident branch home was soon established on the right lines in the Holloway Road with a district superintendent of Miss Lees' own choosing and the support of a local committee of lay sympathisers. Three years later, however, this committee resigned in protest against the dictatorship of the superintendent general—whose view of the incident was that thanks to "the abolishment of the committee" all would now be well. A second district home was later established in Paddington without the incubus of a local committee and all was well from the start.

The rules established for the Association's nurses were wisely directed as much to their health and intellectual training as to their day to day efficiency in nursing the poor. They were required to work a normal eight hour day in their district, but where time was required for lectures or reading, this was reduced to six. This part of their training played a vital part in Miss Lees' scheme and as in Liverpool, was well supported by a medical sub-committee whose members gave their services as lecturers. The nurses were guaranteed eight hours for sleep, at least two hours of leisure daily, and an annual month's holiday.

"Wherever possible" their evenings were their own and only under exceptional circumstances and where due provision could be made for nursing their other cases were they employed on night work. They were not to attend confinements, they might not give relief nor were they allowed to receive gifts from patients or patients' friends.

They were provided with a uniform designed by the superintendent general and by all accounts a reflection of her own excellent taste in dress, combined with grim knowledge of what a district nurse might have to do while wearing it. It consisted of a washable brown holland dress with a long dark blue cloak made by Redfern of Bond Street, and a dark blue bonnet trimmed with light blue piping.

The starting salary of the trained nurse was £35 a year with full board and lodging, rising by annual increments of £3 to a maximum of £50. For her training, she had to pay. In view of the fact that "a common woman" once trained as a nurse could earn two guineas a week with keep, this salary for a particularly gruelling and responsible nursing job scarcely seems adequate.

Loss of Caste

It did however attract recruits of the right class, and in one of her reports Miss Lees uses an unfamiliar argument to explain this fortunate occurrence. Apart from superintendence, she says, ladies "cannot earn their living as simple hospital or private nurses without losing caste among their own kith and kin." Here then is an opportunity for them to work "in an institution where only gentlewomen are received."

Indeed the committee is reminded that "it is yearly becoming more difficult to obtain the common class of women in anything like sufficient numbers for the requirements of our hospitals, and even more difficult if not impossible to obtain good servants. Why then should we tempt this class to take up a work for which hundreds of better educated women desiring employment and with no means of obtaining it, are better fitted."

The Lancet,[1] in general revolt against the " fashion " of handing over nursing in hospitals " to associations of ladies whose bond of union is something outside the institution which they are called upon to serve," was not convinced. " We cannot," so runs its argument, " unreservedly subscribe to the popular belief that nursing (i.e. professional nursing) is an occupation which is at all suited to ladies who have been delicately brought up, and we feel sure that the lady who is ready to perform all these disagreeable duties which are necessary (let us say) for the prevention of bedsores must be a rarity, though we admit that such have been and are occasionally found. Such work is, we feel sure, better entrusted to strong, properly trained women of the lower class who have been accustomed to dirty work from their youth up, and who are never squeamish over their duties. That a governess should be looked down upon while a lady-nurse is regarded as a heroine, is an anomaly due to a fashion which like other fashions will have its day."

Lancet versus Nightingale

But *The Lancet* had always been a hostile critic of the Nightingale thesis—inspired doubtless by the half-conscious reluctance of sub-standard members of the medical profession to collaborate with social and intellectual equals. Indeed during the first year of the Association's work *The Lancet* raised its voice against a long descriptive letter in which Miss Nightingale commended the new venture to readers of *The Times*[2] and asked for money.

Miss Nightingale, said *The Lancet*, was guilty of " somewhat rambling and incoherent precepts." " Her literary style sadly lacked conciseness and clearness. As to her plea for the teaching of cleanliness and hygiene by district nurses, did she not know that the poor disliked interference; the district nurses would soon become unpopular. How could they grapple with conditions in poor homes? "

How indeed? The answer emerges with surprising clarity as one combs through the case records included in Miss Lees' quarterly reports. Here is one:—

" I ought also to mention another case that I went to of acute peritonitis where the doctor said that the woman would probably die before the morning, but that if one of our nurses could attend her at once it might save her. When we went there we found the room close, foul, and in disorder, and that the woman had not been washed or attended to properly since her confinement. We put her into thorough nursing order (and the husband and sister of the patient carried out our directions with regard to the room) and applied poultices, etc., as ordered by the medical man. Before we left the woman said she felt 'much better' and is now quite convalescent."

Then there was a scarlet fever case—a genuine " nursing case " this time, of which Miss Lees writes:—

" I have seldom seen a sadder case than met my eyes on entering the house. . . . The eldest child, a girl, had just died, the mother a slight frail looking woman, had just lifted her out of the bed where the other children lay and had tried to arrange a sort of couch for the dead body on a box near the window. She met us with a burst of gratitude for which I was wholly unprepared. 'Oh how good it is of you to come to us: ' she cried. ' None of the neighbours will come to us, my little Beattie has just died, and I don't even know how to lay her out: I never saw a dead body before and don't know what to do, no more does my husband—he's gone to order her a coffin, but we don't know what to do with her before it comes.' The body of the poor child was in a dreadful state, the doctor in attendance having forbidden the mother (as she told us) to let water touch it. I felt thankful, in spite of the heat, that I had taken a Charcoal Respirator with me, the smell was so offensive. I performed the last offices for the child myself, and made arrangements for someone to be with the other children through the night so that the poor mother might get a night's rest. . . ." Alas, it was too late to save the other children, and Miss Lees was left with the unhappy feeling that had she been called in a week sooner the other children might have been saved from infection, " the mother being so careful to obey every direction given."

Did the London poor resent such cleansing operations by " ladies "? There is abundant evidence to the contrary. Indeed Miss Lees records with pride that " the poor never seem to have an idea that we *are* ladies."

Patient's Misunderstanding

" One old woman, the wife of a mason, said to the nurse attending her, ' Now you take my advice, my dear, and try and get a situation as a nurse to young children in a nobleman or gentleman's family, it ain't half such hard work as you have now, and I'll warrant is a deal better paid than anything you get, and as to the comfort of it! I know what that is, for I have been in service myself and I feel for you, that I do, knowing myself how hard it is to come down in the world '."

Miss Lees is careful to record this, and similar incidents " knowing that some people imagine the poor would object to the service of ladies."

Nor does it appear that the general run of the medical profession supported the line taken by *The Lancet*. Those at the top weighed in as lecturers and committee members. Those in the field: poor law doctors and private practitioners in working-class areas, paid tribute to the value of expert treatment intelligently carried out, and sickrooms transformed from pigsties to " nursing order." The services of the nurses were in keen demand, and the press in general reflected the approval of the doctors.

For this, public propaganda was partly responsible. Florence Nightingale's pen was ever at the service of the Association and few outside the office of *The Lancet* found her style " rambling and incoherent." But Florence Lees played an important part. She had entrée to the drawing-rooms of what is now London, W.1., and

her descriptive lectures on the work of district nurses must have been stimulating and instructive—at times arresting. One "Outraged Matron"[3] writing in *Truth* (June 27th, 1878) refers to the subject matter of six drawing-room lectures given at the house of Mrs. Cowper Temple in Great Stanhope Street, Mayfair, under the auspices of the Ladies' Sanitary Association.

"Outraged Matron" was, she writes, asked by a young unmarried lady to accompany her to one of these lectures. Having paid 3*s* at the door, "amidst a little bevy of footmen we proceeded upstairs and entered a large and elegant drawing-room .... Presently Miss Florence Lees, a pale grave woman about thirty years of age, entered and took up her station in front of a table, on which she slowly unfolded the sheets of her well-considered lecture."

What followed caused "Outraged Matron's" breath "to come and go." Was she "to take her daughter to Mrs. Cowper Temple's drawing-room to learn there is a dark and Haymarkety side of human life of which she never dreamt?... for what purpose, I ask myself—and you—has my young friend been robbed of her innocence, and I of my belief in human nature?"

In the following issue *Truth* lent its editorial support, at great length, to the strictures of "Outraged Matron," and its protests reached a surprising pitch of invective. "... never in antiquity were there women, who as now, blasphemed the natural duties of the sex—who sought to degrade their holiest and highest functions—to terrify the young from marriage and maternity by wild and filthy stories—or to pollute their minds by the premature knowledge of vice and the practical treatment of its results...." And "the ghastly contrast between the simply appalling indecency of the lecture and the luxury of the whole entourage ... must have been more revolting than can well be described."

What can this "pale grave woman about thirty years of age" have said to provoke such furious invective? The answer is revealed by an equally disgruntled correspondent in an earlier issue of *The Lancet*. The syllabus of the sixth of Miss Lees' lectures, one which dealt specifically with obstetric nursing, contained the following headings:— "*Syringing per vaginam. Passing speculum. Method of passing vaginal tube. Various applications for syringing. Plugging and when required, leeches to os uteri. Removal of syphilitic growths.*" This was the last lecture of the course and "Outraged Matron" must have known perfectly well what she was in for when she attended it.

These must have been strenuous years for Miss Lees, and it is scarcely surprising that she was both pale and grave. She was responsible for the household management of the central home in Bloomsbury Square and for the nominally delegated management of the district home at Holloway and later at Paddington. These presented her with constant minor problems connected with heating, plumbing, and damp.

It is not surprising that after three years of this existence she refers to her health as having "deteriorated" and expresses regret at not having made earlier application for assistance in running the central home. It is possible, indeed, that as time went on, the quality of her work and the sense of proportion which conditioned it, would have suffered, as potentially great work so often does, by over-concentration and inability to delegate. From this fate she was saved by the fact that she was to find emotional satisfaction in a personal relationship.

From its early years the Association's work had been supported by the Rev. Dacre Craven, Rector of St. George the Martyr in Queen's Square and chaplain to the Great Ormond Street children's hospital.

From Miss Lees' point of view he had all the right interests, in addition to being a man of great intelligence and exceptionally pleasing appearance. Their marriage in 1879 initiated a partnership which lasted until his death in 1923. She died a few months later at the age of 82.

Miss Lees' marriage did not deflect her from district nursing activities. It was not a case of her being drawn *out* of them. Dacre Craven was drawn into them. He was in fact an unusually co-operative Victorian husband. As far as she was concerned, marriage meant a change of residence from Bloomsbury Square to Great Ormond

MISS KATHLEEN PAGET

THE death on 27th May 1959 of Miss Kathleen Paget, an Honorary Secretary of the Queen's Institute, severs a striking link with the origins of district nursing. Miss Paget was a niece of Dame Rosalind Paget, the first nurse on the Queen's Roll and the first Inspector of Queen's nurses, whose uncle, William Rathbone, founded district nursing in Liverpool.

Miss Paget first served on the Institute's Nursing and Midwifery Committees in 1932. In 1935 she was appointed to the Council.

In 1942 Miss Paget became an Honorary Secretary, an office which she held up to the time of her death, regularly attending all Institute meetings. During the war years she readily undertook the onerous duties incumbent on this office. Her advice, frequently sought, was always wise and just, and her manner kind and gracious.

For many years an honorary officer of the Newark Nursing Association and of the East Sussex County Nursing Association, Miss Paget had a wide knowledge of nursing in rural areas.

Public health nursing was only one amongst a variety of interests Miss Paget had in the nursing world, and she will be mourned far beyond its bounds. But the Queen's Institute in particular is grieved at the loss of one of its oldest and most loyal friends, and at this severance of a link with the past.

Street, but if in fact she had dominated her committee as Miss Lees, she continued to do so as Mrs. Craven, having " at her own wish " been appointed " with full powers and responsibilities as before " as non-resident superintendent general without salary.

It was fortunate for the Metropolitan and National Association that the marriage of its superintendent general did not evoke the familiar dialectic of " home versus career "; for not long after the translation of Miss Lees into Mrs. Craven it ran into the rough waters of financial crisis; and for a dark moment its very survival hung in the balance. In spite of the spectacular triumph of its ladies over conditions which no lady could be expected to encounter without nervous or physical collapse, in spite of the social and political eminence of its lay patrons and the enthusiastic approval of the best brains in the medical profession, in spite of powerful support from the great Miss Nightingale herself, in spite of the highly skilled home nursing which admittedly and for the first time as a systematic service was being rendered to the London poor—in spite of all this, financial support fell away. The secretary's letter-book records a valiant effort of personal begging-letter writing —to old subscribers and potential new subscribers, to organisations, business firms and newspapers.

About to Close Down

By October 1880 subscriptions and donations had so dwindled as to suggest that the organisation could no longer be carried on. A month later Mrs. Craven was instructed to give three months' notice to all nurses in the homes under her general superintendence.

Meanwhile a special committee was set up to consider the reconstitution of the Association " on a more self-supporting basis." In the following January a meeting of associates at which only 15 were present, resolved to wind it up, after which a donation of £100 from the Duke of Westminster was returned to him in view of its anticipated extinction. But the Association was in fact a living organism with the seeds of abundant life in it. It could not die. Its more ardent supporters racked their brains—and their pockets. Less than three months later it arose again from the dead.

There can be little doubt as to where the lion's share of credit—though not by any means the whole of it—for this rescue operation should go. At an annual meeting two years later William Rathbone congratulated Mr. and Mrs. Dacre Craven on the " success of their efforts." Between them, and with devoted support from the committee, they had nursed the Association through a dangerous and possibly fatal wasting disease. It was now " in good nursing order " and ready to spawn district centres all over London and play its part in an exciting and expansive new chapter of district nursing history.

In 1889 Mrs. Craven published a small manual[4] for the use of district nurses, which ran into several editions. It reflects her experience of years spent in and out of poor homes at a time when housing and sanitary conditions had scarcely felt the impact of social legislation and administrative reform. Here is the London of Charles Booth's great social survey with its stark disclosures of the nature and extent of primary poverty—in which he says, writing of this contemporary London: " Of all the forms that charity takes, there is hardly one that is so directly successful as district nursing. It is almost true to say that wherever a nurse enters, the standard of life is raised."[5]

Mrs. Craven's book opens with her familiar thesis regarding the need for superior education and breeding in the service of district nursing, in view of the tasks to be performed and the influence to be exerted. At the same time, she reminds her readers, the district nurse " must be content to be servant to the sick poor and teacher by turns. Wherever she enters order and cleanliness must enter with her. She must reform and recreate, when necessary, the homes even of the poorest and most wretched. She may have to bring about this result with her own hands, to sweep and dust and empty and wash out all the dirt and foulness she finds. . . ."

There follows a detailed list of her necessary nursing equipment, and instructions as to the arrangement of a sick room. Much improvisation will of course be needed; and directions are given as to how a blind can be constructed from two walking sticks and two nails, a mop from tow wound round a stick of firewood, a bronchial kettle from toy peashooters, a bed pan from a dustpan or a soup plate.

The patient is the focus of it all; the patient's susceptibilities, however irrational and indicative of futility or weakness, must be respected. And the reader is told how, when all else fails, the nurse can, by careful attention to posture, ease the passage of the dying—and how, after a moment of quiet prayer by the bedside, she can so perform the last offices as to soften the crudity of death for those who are left behind.

Let us then form our picture of Florence Lees at this point—not in her capacity as superintendent general, stern mentor of the sub-standard nurse, scourge of the well-meaning amateur—but as " servant to the sick poor," bringing her own skilful hands to the relief of pain and the redress of disorder—

" . . . and smoothing
Distortion down till every nerve had soothing
And all lay quiet, happy and suppressed."

End of Instalment IV.

REFERENCES

1 *The Lancet* 20th December 1879.
2 *The Lancet* 22nd April 1876.
3 The word ' matron ' is clearly used here in the Roman and not in the hospital sense.
4 *A Guide to District Nurses and Home Nursing* by Mrs. Dacre Craven. Macmillan & Co. 1889.
5 *Life and Labour* by Charles Booth. Final vol. p. 157.

The author completes her European study tour and sums up her findings

District Nursing in the Low Countries

by ISOBEL H. MORRIS, S.R.N., S.C.M., Q.N. and H.V. certs.

THE NETHERLANDS

ALL factors relating to public health in the Netherlands are supervised by the chief medical inspector and his medical inspectors. There are twelve departments. The majority of the directors are doctors (specialists in their own field). Thc others include a nurse, a dentist, a statistician and an engineer.

The nine medical inspectors act as liaison officers between the Government and the different organisations and societies working in the public health field. The most important of these are the Cross organisations; the Green Cross Society (neutral), the Yellow White Cross (Roman Catholic) and the Orange Green Cross (Calvinist).

Voluntary committees or local boards of these societies provide and maintain the public health nursing service in the areas they serve. Among other things they establish welfare centres, employ suitably qualified staff and furnish them with equipment. In many of the cities the municipalities provide the services but outside the urban areas the Cross organisations are almost entirely responsible. The Government give substantial grants to assist the voluntary organisations and by so doing are able to lay down certain standards. But the object is always to foster the voluntary spirit rather than overrule it.

A senior advisory nurse is appointed to each province, and throughout the provinces are supervisory nurses in specialities such as cancer, rheumatism, maternity and child welfare. The field workers are the public health nurses employed either by the Cross associations or the municipalities. These nurses are designated as district nurses.

Miss Hooykaas, the chief advisory officer, stressed two points of great interest. The first was the policy of having one all-purpose nurse visiting the homes to undertake preventive and curative work. It is hoped in time to implement this policy in the large cities where the work is still specialised.

Secondly, that the district nurse should be autonomous and a practitioner in her own right. Of course this does not debar doctors from giving instructions regarding treatment but it excludes the nurse from direct supervision by senior officers. The supervisory nurses in the specialities (cancer, rheumatism, maternity and child welfare, etc.) work in an advisory capacity. The nurse is free to accept or reject their suggestions. There is no doubt that the keynote to the success of such a system is good human relationships.

District Nurse Training

There are fourteen public health nurse training centres in the Netherlands. I visited Rotterdam where the Green Cross Society has established a training centre at their provincial headquarters.

Applicants for the course must be registered nurses who have completed six months maternity nurse training. The training takes approximately ten months. The theoretical part is divided into two sections. The first takes four months and is followed by four months practical work. The course ends with the second theoretical section of about seven weeks.

Subjects include personal and community hygiene and sanitation; public health legislation; sociology and social legislation; public health nursing, administration, principles of interviewing, health education, maternity, child welfare and school health services; control of tuberculosis, venereal disease, alcoholism, prostitution, rheumatism and cancer; mental hygiene, psychology of child and adult; care of the diabetic, the handicapped and the aged.

During the practical training the candidate spends one month with a district nurse working in a rural area, studying the tuberculosis service, paying home visits and receiving practical instruction in the work of an infant welfare centre. She spends three weeks with the school health service, and makes observation visits to places of interest associated with the public health course.

At the end of training the candidate is examined by her teachers in the presence of experts designated by the Minister of Social Affairs and Public Health.

Welfare Centres

One of the functions of the Cross organisations is to provide and maintain welfare centres. I visited the centres in Mordrecht, Waddinxvean, Boergoense Vliet and Petumahof.

Those at Mordrecht and Waddinxvean have been purpose built. The Boergoense Vliet centre is a conversion of the ground floor of an older type of dwelling; the one at Petumahof is a specially adapted ground floor flat in a block of flats on a municipal housing estate.

All these welfare centres are cheerfully decorated and well equipped.

Amongst features common to all welfare centres are:

A large entrance hall with a wide doorway and a ramp. The children are wheeled in their prams into this hall.

An undressing or box room. Each mother is given a tiny compartment in which a wide folding shelf of convenient height extends from side to side. The baby is laid on this shelf and undressed.

A tiny isolation unit which leads off the main entrance hall and communicates with the doctor's room.

A loan store where articles such as bedstead, sorbo mattresses and other articles of nursing equipment are kept.

Some centres include flats for the nurses and others accommodation for the caretaker.

The local doctor or a paediatrician holds special clinics for infants and toddlers. The nurses have no separate consulting room, but sit at a table in the room where the children are undressed.

All children are taken to see the doctor. There is no selection. The doctor always advises on feeding, but the nurse gives the inoculations. Attendance at the welfare centres is high.

Talks on matters relating to health are given at the centres, usually in the evening, by the nurse supervisor of the area, and other experts.

I was taken on an afternoon round with a district nurse working on Overschie, a new housing area on the outskirts of Rotterdam. Four district nurses operate from the Green Cross centre in this area. Two live in a shared flat over the centre. The others provide their own accommodation. The nurses undertake preventive and curative work.

There appears to be no difficulty in combining preventive and curative work. The district nurse plans her day to meet the needs of the families and patients in her area.

I gathered that from the beginning the relatives are instructed in caring for the patient and it is made clear to them that once the acute stage is over the main responsibility for the nursing will be theirs.

Nurses have weekends free except once a month when they take a turn at being on call and visiting urgent cases. A small allowance is given for the purchase of uniform, but there are no specific rules about wearing uniforms.

A great many problems present in other countries do not appear to exist in the Netherlands owing to the fact that few married women go out to work. Even so a domestic help service is organised and fully used. There are two kinds of domestic help, home makers and home helps.

Centres for the training of home makers exist in all the large cities. Recruits vary in age from 20 to 60 years, but usually they are in the younger age groups. The training lasts for eighteen months, during which lectures in housewifery and child care are given.

The practical training consists of supervised practical experience in selected families. The home makers pay for their own training but can obtain help from the training body. In that case they agree to serve a two year contract. Once trained the salary ranges from £20–£30 per month. They are responsible for making their own living arrangements.

The home maker takes full charge of the family during the incapacity or absence of the mother. The initial period of two weeks can be extended if necessary.

She attends the family for eight hours from Monday to Friday and four hours on Saturday. She wears an attractive uniform of a green cotton dress with white collar and cuffs and a white apron.

I saw two home makers at work. In the first family visited the mother was nearing the end of her tenth pregnancy. Despite the fact that the home was poor, thanks to the home maker it was remarkably clean and orderly. A long line of washing hung in the back yard. The children playing about were obviously fond of the home maker.

In the second family the mother was suffering from a nervous condition. It was clear that the responsible and efficient household care the home maker was able to give was helping towards her recovery and the well being of the family generally.

Home helps visited the family for four hours each day. Although accepted without training, home helps are given a series of evening lectures. They receive the equivalent of about 2*s* 1*d* per hour.

The Maternity Aid Services

In the Netherlands midwives take a three year training in one of the three midwifery training schools in the country. If they are registered nurses the training is for two years. When practising as domiciliary midwives they work independently and are practitioners in their own right.

Of the confinements in the Netherlands 78 per cent take place at home, as a result of the provision of maternity aids who work in the homes and take care of the mother and baby for ten to fourteen days after the confinement. The midwife or doctor continues to act in a supervisory capacity but the maternity aid sees to the nursing of the mother, the care of the baby and looks after the household generally.

In order to carry out such responsible duties satisfactorily the maternity aid is given a special training at one of 160 maternity centres. The Cross societies, with the assistance of Government grants, maintain many of these centres. They are established in districts where at least 1,000 confinements take place each year. A matron, usually a registered nurse and a qualified midwife, is in charge.

I was able to visit a Green Cross maternity centre, a converted detached house with a classroom, office and living accommodation for the matron.

Maternity aids are recruited from women between the ages of 19 and 40 years. The pupils undertake fifteen months training, and are taught anatomy, obstetrics, care of mother and baby, nutrition, cooking and laundry. Visits of observation are paid to places of particular interest and the pupils attend selected families and work

under the close supervision of the matron. While so doing a small monthly allowance is paid. At the end of the course an examination is taken; successful candidates receive a certificate and badge.

The maternity aid may attend the mother during her confinement and assist the midwife or doctor at the delivery. Afterwards she will attend each day from 8.0 a.m. until 7.0 p.m.

I accompanied the matron of a centre upon a supervisory round. No notice of our visit had been given beforehand. We called at a variety of homes—a farmhouse, a newly built bungalow, a workman's cottage and a dwelling very clearly converted from a railway coach. The cleanliness and orderliness of the homes impressed me very much, but even more so the relaxed, contented state of the mothers. They looked comfortable and well cared for, the babies were sleeping in separate cots and without pillows. One newly delivered mother of a first baby was having difficulty in getting the child to feed and the maternity aid was sitting beside her and helping her.

As in so many of the services I saw during my study tour I felt that the skill and enthusiasm of the matron in charge was responsible for the highly efficient service given by the staff.

Old People's Home

I saw only one example of accommodation provided for old people in the Netherlands. This was an old people's home in the town of Gouda, well known as a cheese making centre. This home, run by the Dutch reformed church, provides unfurnished bed-sitting rooms and flats. Several nurses are attached to the home. They give weekly baths and other attention to any old people requiring help. There is also a sick bay for those who need constant nursing care.

Welfare Therapy

I had a surprise when I learned that welfare work under the Red Cross in the Netherlands was the provision of an occupational and diversional therapy service for both hospital and domiciliary patients. There are two kinds of occupational therapists: the salaried occupational therapists who receive one year's training and work mainly in hospitals; and voluntary unpaid occupational therapists who are given a course of instruction of two and a half to three hours each week for ten weeks and who afterwards visit people in their own homes.

Patients are taught different kinds of occupational therapy in hospital but many still require help and guidance after discharge. A trained occupational therapist continues to visit them in their homes.

In some areas an increasing number of patients requires the occupational therapist's help. When this is so and there is also a need in the district for others to have diversional therapy in their own homes the headquarters of the welfare department of the Red Cross is notified and they in turn inform the local chapter. A recruitment campaign will then be organised for women (over twenty-three years) to train as voluntary occupational therapists.

A wide variety of materials for handicrafts is obtainable at cheap rates from a central store. The therapy undertaken by the voluntary occupational therapists in the homes is solely diversional and not intended to provide financial support.

Anti-tuberculosis Centre

Rotterdam is a city of achievement. A fine new town has arisen from the bombed ruins of the old. The harbour nearing completion will be the largest in the world. The sense of purpose which pervades the city (not one strike or industrial dispute since rebuilding started) is demonstrated by the way in which the tuberculosis problem has been tackled.

This specialist service in Rotterdam is operated from the municipal health centre where offices, laboratories, consulting rooms and an x-ray department are grouped together on one floor.

Some points are worthy of note. The tuberculosis health nurses employed by the municipality although fully qualified are required upon appointment to take a further course in social work, during the evenings over a two year period—approximately four hours per week. The municipality pays 50 per cent of the cost and the nurse undertakes to work as a tuberculosis health nurse in the municipality for at least two years.

Should a case of tuberculosis be diagnosed all relatives, friends and neighbours are invited to come for examination. 200 people have been known to come following the discovery of one case of tuberculosis.

Sanatorium treatment is always offered to the patient. If he or she refuses, the family doctor undertakes the care of the patient at home and administers any treatment required.

The tuberculosis health nurse makes a very careful investigation into the social conditions and history of the patient. A full report is passed to the sanatorium with any recommendations considered necessary.

The tuberculosis health nurse visits the sanatorium once a month. Patients are informed of her visit and if any wish to consult her about family matters or social problems, they are free to do so.

BELGIUM

Dr. Goosens of the Belgian Ministry of Health gave me a warm welcome to his country. He spoke of the many aspects of Belgian life and presented me with some literature which had been specially prepared for visitors.

St. Peter's Hospital, designed by an American architect was built in the 1930s through the Rockefeller Foundation. It is associated with the University of Brussels. The hospital has about 350 beds and a large out-patient department. As well as the usual facilities it possesses a special class room for debilitated child patients and a welfare centre where mothers may bring their healthy babies.

This hospital is situated in one of the poorest parts of Brussels. It is a hospital in the widest sense in that it is a health centre for the whole district around.

This object has been achieved in four ways: first by teaching nursing staff the principles of preventive medicine throughout their general training; secondly, by giving a further course in public health work to selected graduate nurses who wish to become medico social workers; thirdly, by employing these qualified nurses to undertake preventive medicine in all departments of the hospital and on the district; lastly, by the maintenance of a central record room where all medico social information concerning families is collected and co-ordinated.

The school of nursing is separate from the hospital although under the same matron. Only students of good educational standard are accepted for training which covers a three year period. From the outset of training public health is integrated into the course.

Public Health training

There is a one-year post-graduate course of public health training for students with a good foundation in general training. The course is designed to give the student a broader and deeper knowledge of the public health and social services. Individual case studies are undertaken and visits paid to places of special interest.

A medico social service was inaugurated at St. Peter's Hospital in 1935. Later a community nursing service was started. After the war the service was extended to other parts of the city. The public health nurses attached to St. Peter's hospital have therefore a three-fold function. They are based on the various out-patients departments of the hospital. They undertake the preventive health work in a defined area outside the hospital; and thirdly they nurse the sick in their own homes.

Public health nurses working in the hospital interview all new patients coming to the department with which they are concerned. If necessary they pay home visits to advise upon the desirability of hospitalisation or home care and to investigate social problems. They accompany consultants on ward rounds so that they may be available to give relevant information concerning the social background of the patient. The public health nurses are concerned with the rehabilitation of the patient during the stay in hospital and after discharge.

Six public health nurses undertake the nursing care of patients in their own homes. The majority of these patients are referred through the hospital although local doctors can apply for the service for persons receiving national assistance.

Ancillary services

Patients nursed in hospitals have many material advantages which are not always available in their own homes. So that they may assist those who lack certain amenities to remain in their own homes the medico social department of the hospital provides bed linen which is loaned and laundered by the hospital, and nursing equipment such as bed pans, mattresses, etc.

Domestic help is supplied in the form of trained household aids. These are women who have taken eighteen months training in elementary home nursing and household care. They work under the supervision of the public health nurse.

I spent a very pleasant afternoon with a young household aid. She had received her list of visits from the public health nurse with whom she worked. The persons paid for her services according to their means. All of those we visited were receiving national assistance, so no charge was made.

I left St. Peter's Hospital and went on to see something of the work of the Yellow and White Cross of Belgium. This was founded in 1945 as a specialised domiciliary nursing service. Families can become members of this society by the payment of 150 Belgian francs per year (just over £1 sterling). This entitles any member of the family to free nursing care at home at the request of the patient's doctor.

I visited the headquarters of this Society in Brussels where the director showed me over the building and described the pattern of the organisation. The Yellow and White Cross has branches in most of the large cities and there are nurses working as domiciliary nurses in the rural areas throughout the greater part of the country. The country is divided into regions and a monitress, attached to the headquarters staff, supervises each region. A head nurse is in charge of each local branch.

The Society employs registered nurses and a very small number of assistant nurses. No special district training is given to these nurses before starting domiciliary work although some of them have taken a course in social medicine. Social workers are attached to the large branches and act in a consultative capacity.

A monitress took me to visit two centres. Each was provided with office accommodation and a store for nursing equipment. At some centres residential accommodation is available for the nurses but the majority find their own. A number of cars are provided for the nurses' use. As a general rule clerical staff take messages throughout the day but written instructions from the doctor are required on behalf of each patient. The head nurse pays the first visit to each new case. Afterwards the nurse in whose district the patient lives takes over the nursing care. There is no supervision of nursing staff.

The nurses telephone in to the centre for their work and by means of a shift system undertake morning, afternoon and late night rounds. They fix a regular time for visiting their patients each day.

There are 136 registered nurses working for the Yellow and White Cross in Belgium. In 1957 they paid 652,951 visits to 60,602 patients. During the fourteen years of its existence this service has developed rapidly. There is no doubt that given the necessary staff it will grow even further in the future as the demand on the service continues to increase.

Conclusions

In each of the three countries I visited the preparation of the public health nurse showed many similar features. She is taught the principles of social and preventive medicine and the theory she learns is integrated with field work putting this teaching into action.

Only in Denmark, where (except in an experimental area) the services are specialised, is the nurse undertaking domiciliary nursing given any special instruction in this particular branch of the work. In the Netherlands where the policy is to have one public health nurse, it seems a sad omission that no teaching and demonstrations on the adaption of bed-side nursing skills to home conditions are given.

No doubt in time the Yellow and White Cross of Belgium will introduce a district training for the registered nurses it recruits for domiciliary nursing.

Both the public health nursing and the home visiting services are quite well developed in Denmark, but there seems to be little co-operation between the two sections. I think the service as a whole would benefit by the appointment of provincial nursing officers who would co-ordinate and integrate the services.

In all three countries I was particularly struck by the fact that the nurses undertaking domiciliary nursing, whether as a specialised service or linked with public health work, receive no direct supervision. In the Netherlands and Belgium I was astonished at the small amount of nursing equipment they carried in their bags. I was greatly impressed by the record room at St. Peter's Hospital, Brussels, where public health nurses could get all available information concerning the medical and social history of the family they were called on to visit.

The question of the supervision of trained staff is a very debatable one. I personally feel that it is necessary particularly when nurses are working in outlying areas without the benefits of close professional contact. In my opinion supervisors should be regarded as consultants and advisors and the nurses should be taught to use them in this capacity.

Although I feel that the nursing equipment carried by the nurses in the Netherlands and Belgium was inadequate to perform some nursing techniques, nevertheless I think our district nurses tend to be overloaded and could carry far less without any detriment to the service.

The assembling of information for record purposes at St. Peter's Hospital seems an admirable piece of work.

The Ancillary services

The domestic help ancillary services were divided into two groups; those to whom no special training was given (or very brief introductory course) and those who had a comprehensive course of instruction lasting eighteen months. The longer course given in the Netherlands and Belgium seemed to me unnecessary for the type of work undertaken. On the other hand the selection and training gave the workers a status which probably aided recruitment and raised standards of work.

The organisation of the service sometimes comes under the director of the public health nursing services as in Denmark and Belgium, or under one employing body but with a different director as in the Green Cross Society in Holland. Alternatively, as in parts of Denmark it is administered from the Social Welfare Department.

A very satisfactory result appears to be achieved where the domestic helps work under the director of the public health nursing services. It is then possible for one person to assess the family's total need. Also it allows for easy adjustment of personnel as circumstances in the family change.

The hours which the domestic helps work in Denmark are of interest. By fixing the maximum at two hours per day and the minimum at two hours a week the greatest use can be made of available labour. Such a system however can only work in a flat dwelling community because of the time otherwise lost in travelling.

Denmark showed a great sense of responsibility towards her ageing population. Even on crowded public transport a child or adult would not take a seat before looking to see if an aged person was standing.

The well organised domestic help service demonstrates one way in which the needs of the aged are catered for. The other outstanding example is the accommodation provided in ways which have been described. (June p.55)

I was particularly impressed by the schemes which ensure an independent way of life for the old people even though amenities such as means of communication, communal meals and cleaners are always at hand with nursing staff available on the spot if wanted.

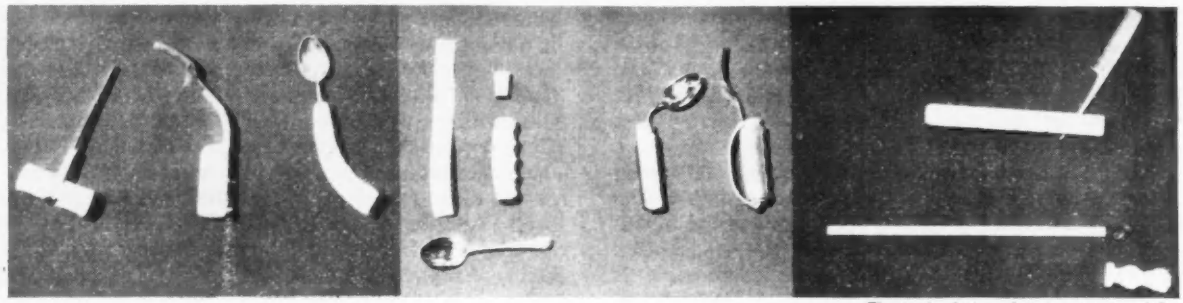
I thought the grouping together of so many old people as occurred in the Old People's Town in Copenhagen was not really desirable but I understand that this plan is not likely to be repeated in other housing schemes.

In Denmark and the Netherlands the incidence of tuberculosis has fallen to a marked degree and neither country has found it necessary to call on the public health nurses to undertake domiciliary nursing care of the tuberculosis patients even when the disease was at its highest level.

Wide use is made of day nurseries in Denmark where so many mothers go out to work. The reverse is the case in the Netherlands. The provision of leisure hour schools as seen in Denmark seems an excellent idea. My knowledge is too limited in this respect to suggest that it would be a good thing in this country.

The scheme whereby the Dutch Red Cross train voluntary workers to teach occupational therapy to disabled or sick people in their own homes is admirable. I am convinced that many of the patients we attend would benefit from such a scheme.

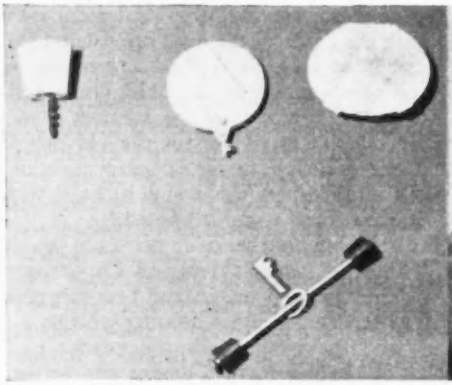
Finally, I should like to say that I thoroughly enjoyed the experience which the fellowship afforded. Everywhere I experienced the greatest kindness from those whom it was my good fortune to meet; without exception all were unsparing of themselves in showing me the services in which I was interested. It was indeed heartening to realise we all had the same objective—to preserve health and when this failed, to restore or relieve.



The knife, fork and spoon, extreme left, have plastic handles. Centre, an ordinary handlebar rubber gives a grip for crippled fingers. Above, the comb is fixed in broomstick handle: and a clip on a dowel rod takes the shaving brush.

Everyday Aids for the Disabled

The Central Council for the Care of Cripples has prepared a film strip at St. Margaret's Hospital, Swindon, produced by 'Camera Talks, London', showing how a little ingenuity with inexpensive materials can make life for the disabled a lot easier and more independent. In many cases some apparently small help makes the difference between dependence and independence. Such aids have great psychological as well as practical value and have become a recognised part of rehabilitation.

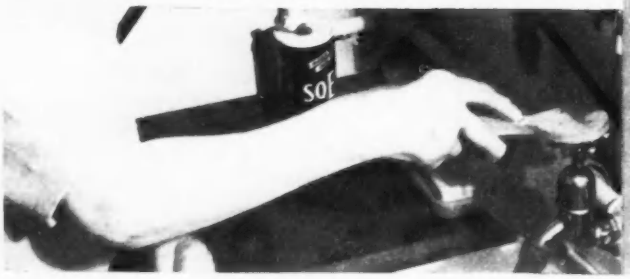


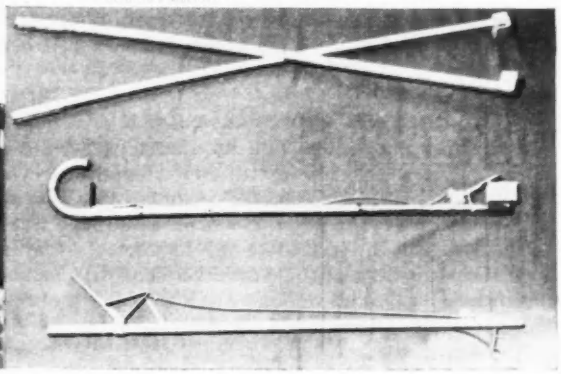
Some suggestions for overcoming difficulty in turning keys and handles. The enlarged key handles can be made of wood or metal. Right. A padded tool made from a length of dowel rod and a cut-down coat-hanger, can be used to take the weight of heavy clothing.

A piece of wood—it could conveniently be the back of a bath brush—and four brass screws may help in turning screw-topped water taps.

Here the extension tool is seen in action. The subject fits the screws over the taps and is able to turn water on and off, unaided, as she needs it.

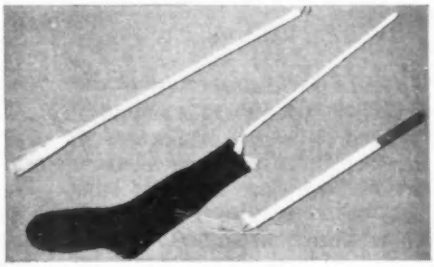
These wooden pick-up sticks are simply made and illustrate differing types and movements. First is a scissor tool; in the middle a sprung steel clip attached to an ordinary walking stick: below, a trigger action controlled grip. Right, the sprung steel stick in action.

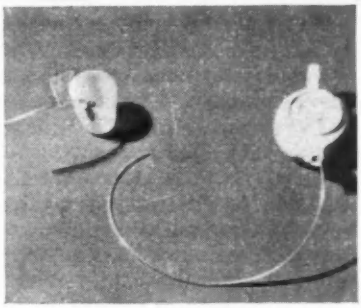




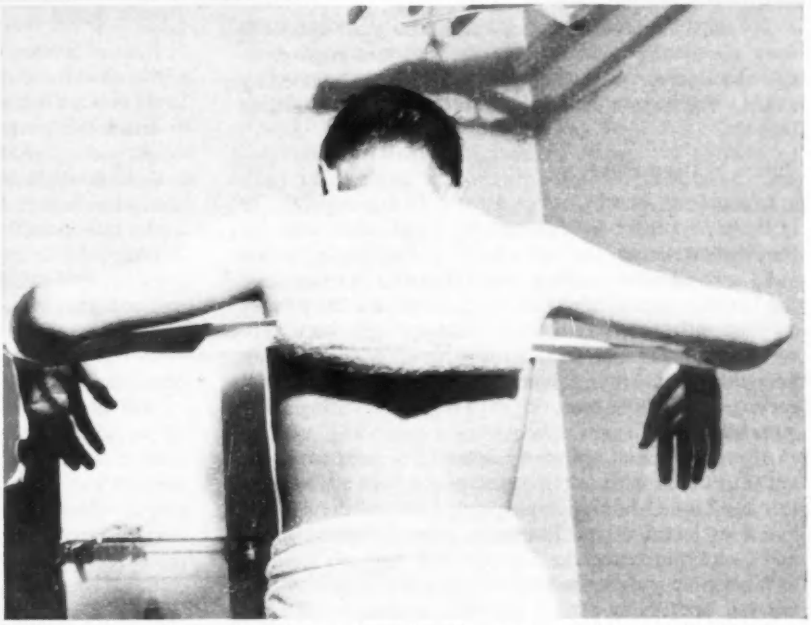
Two simple aids permit patients who cannot bend their knees, to put on their own socks and stockings. Extreme left, manufactured in plastic, is the stocking equivalent of a shoe horn. Next to it an embroidery frame is attached to two lengths of cord: the stocking passes through the inner ring and is turned back and held in place by the outer ring.

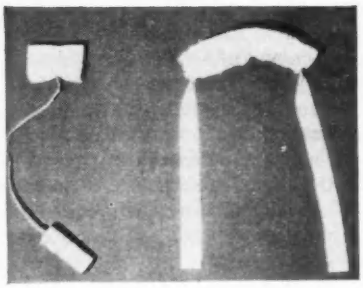
For a man's socks we have two dowel rods with ordinary cup hooks screwed on to the end. A patient unable to grasp rods could use tape loops. Also in the picture, a suspender attached to a wooden handle, is another aid for pulling on socks: and for shoes, a shoe horn becomes practicable when it is fixed to the end of a rod.





Those who cannot lift their arms find drinking a difficult feat. Polythene tubing is useful here. A short length may be clipped to the side of a beaker, or a longer piece can be inserted in the spout of a small teapot or feeding cup.





The bathroom naturally is a place where the disabled would most welcome the means of independence. The long handle of the aid on the extreme left is constructed from twisted fencing wire, which is both light and flexible. It holds a sorbo sponge.
The second aid consists of a loofah, sponge or padded roll of flannel, with a length of webbing sewn to each end. Loops are made in the webbing so that someone with limited arm movement may slip these loops on to his wrists and wash his back effectively.

District nurses are helping the paraplegic back to a normal life to become again a useful member of society

I Am A Paraplegic

by REV. A. H. BULL, B.D., Hon. C.F.

IT seems a long time back now, for it was in July 1943, fifteen years ago, that a shell from an Italian gun hit the landing craft on which I was sailing for the coast of Sicily. I had jumped into the water to make for the beach when it happened.

I felt terrific pain at first. Then quite suddenly the pain disappeared as half my body and legs became paralysed. To prevent myself from drowning, I had to turn on my back and swim to the shore.

Eventually, I was pulled out of the water and taken to the Regimental aid post. After a number of " night-mareish " experiences, including being taken out on a landing craft to look for a hospital ship which had been sunk, we had to return to Sicily. We had left at about five in the afternoon, and we returned at about two in the morning. I was cold, sick and miserable. Later that day I found myself on a ship bound for Tripoli.

In hospital I was in good hands but when I saw a suprapubic catheter sticking out of my tummy, I asked the M.O. how long I should live with a thing like that in me. Needless to say, he reassured me.

My worry was whether I should ever walk again. It took me a long time to pluck up sufficient courage to ask the doctor. I wish he had told me without being asked. The news that I should not was a blow hard to bear.

Future Without Hope

It was four months before I got back to England, for in those days there were no aeroplanes for casualties and the Mediterranean was not yet open to shipping. When I did arrive in this country I was sent to a hospital near my home. I was treated with great kindness but I faced a future in which there seemed to be but little hope here on earth. There seemed to be no chance of ever leaving hospital. Sometimes I had a trip around in a spinal carriage but there was no suggestion of sitting in a wheelchair.

After a year in hospital in England, by good fortune I got into touch with another paraplegic who advised me to go to Stoke Mandeville hospital. None of the doctors had ever heard of it. Enquiries were, however, made and I was transferred there.

What a very different state of affairs I found. I was not just one lonely paraplegic with no one else like me and the doctors not knowing what to do to help. Here everyone else was a paraplegic and best of all the doctor in charge, Dr. Guttmann, was quite confident that in time all of us could be brought back to such a state of health that we would be fit to go home and to do a job of work.

Of course, it all took time; there was the long and weary process of getting rid of the most horrible and persistent bedsores; learning to get about in a wheel-chair and to dress oneself. Physiotherapy, occupational therapy and games all played their part.

Eventually one was allowed to go home for a week or so to see how things would work out, and whether one's house could be adapted to a wheelchair life.

It is on such occasions that the help of the district nurse can be invaluable, especially in helping with dressings.

I was at Stoke Mandeville about three years before I was able to go home and look after myself. What a joy it was when I was given a car by the Ministry of Pensions and I began to get mobile again. I am a Church of England parson. While in hospital I had helped a bit with the services, but now I began again to preach at the parish church and to do other jobs as I was able.

Mobile Again

It is, of course, no easy task being a paraplegic. One always has to be on the watch for pressure sores, knocks and bruises. It is all too easy to burn oneself. It is easy to break one's legs, as I know to my cost. One is liable to get kidney and bladder troubles and so on.

As I look back, however, to those days when life seemed to hold so little in store for me, I am quite amazed at the measure of physical fitness that I have achieved. I am lucky in that I can use my arms, and when anything goes wrong I fly back to Stoke Mandeville.

The higher lesions, who cannot use their arms, or who can use them only a little, need a great deal of help. For many only the assistance of the district nurse makes it possible for them to go home.

Thanks to the work at Stoke Mandeville, the treatment of paraplegics today is very different from what it was in 1943. The new lesions who arrive there now are very often fit and well enough to go home within a few months. But we all need a certain amount of help and assistance—some more than others. When much of your body is paralysed, you must be continuously on the watch and things sometimes go wrong.

District nurses are playing an essential part in this great work of helping the paraplegic back to a normal life, and making him once again a useful member of society, and not just a burden to himself, his family, and everyone else.

The prize-winning essay in the B.M.A's 1959 competition for state registered nurses working outside hospital

The Social Services and How to Use Them

by SUSAN JONES, S.R.N., S.C.M., H.V. Cert.

THE history of the development of the social services in this country is one of slow evolution over centuries. Years of patient endeavour, devoted effort in the face of strong opposition, trial and error in many fields by individuals and groups, starting as isolated pioneers, feeding on their own success and determination, and emerging as the complex web of voluntary and statutory services we know today.

As a system, it has excited comment and criticism from all over the world; and it is generally recognised that in few other countries are people offered so complete a background of social security against which to grow and develop. To achieve its highest objective, this system must be understood, and used intelligently and with good will, by the whole population of the country, and particularly by those who have accepted the responsibility of working within it, and helping to interpret its value.

Different parts of the social services have grown independently in answer to the needs that brought them into being, and have progressed at different rates, and often in complete isolation from other efforts going on alongside them. This resulted in an uneven quality in the scope, function and development of the many departments involved, and sometimes in duplication and overlapping of services, and uncertainty as to where responsibility for a particular function rests.

Legislation has done much to lessen the differences in quality, by allocating responsibility and directing funds for expansion and growth where necessary; but the full potential of the scheme for social insurance cannot be realised without understanding co-operation and intelligent use by all the people of this country, and particularly by those employed in the social services. Without this, the scheme is in constant danger of abuse from ignorance, carelessness and indifference; and the balance which should be held between the administration of the social services and their use by the public, between satisfactory supply and satisfied demand, is likely to be disturbed.

One necessary advance is in an understanding of the cost of these services, and a knowledge of the sources of the money available to finance them. It is a debatable point whether the freedom from an immediate charge for a service tends to encourage a profligate and irresponsible demand, and there is a danger that a widely spread financial insurance against sickness, old age and unemployment may breed a greater lack of forethought and personal effort to safeguard the future.

Among the general public there is a widespread lack of knowledge of the scope of the social services, and of the function and responsibilities of the different people employed in them. This makes for confusion in seeking help, and a sense of grievance if the agency approached fails to supply the aid sought. There is a good deal of unnecessary suffering and deprivation among people who either do not know of facilities available to them, or how to obtain them; or hesitate to seek them, for fear of submitting themselves to an unsympathetic scrutiny of their lives and circumstances.

At the other end of the scale are those people who seek to use to the full all the services, and are only too glad to shuffle off all personal responsibility for themselves and their families. They regard a humane welfare state as fair game, to be exploited as fully as possible.

Between these two extremes lies the bulk of the population, interested in providing for themselves and their neighbours a comprehensive service, and desirous of using the facilities provided intelligently and economically.

The Public Needs to Learn

There is need for education of the public in the provisions of the social services, in their economy, and in their efficient functioning. It would help to build up a responsible attitude on the part of people using them, and an intelligent interest in their development.

Schools and youth clubs supply a fine audience for the teaching of good citizenship. They should meet representatives of all the social services, so that by listening, questioning, and where possible seeing for themselves, they can follow the growth of these services to their present state, and on to their possible development and expansion in the future.

Adult groups are always on the lookout for speakers and subjects of general appeal. They offer local workers in the social services an opportunity to explain their functions; and again to foster a responsible attitude and understanding of what is available to the public, and how they can help to maintain its efficient working. Much can be done through such mediums as the press, cinema, radio and television that reach a wide audience, to present all the diverse workings, and to show how they affect the lives of us all.

Apart from the better use of the services offered, this wider knowledge of such things as provision for handicapped children and adults, the work done in our hospitals and surgeries, and efforts to reclaim and re-establish families and individuals who have allowed themselves to fall below accepted standards, will surely foster a greater sympathy and understanding of the more severely burdened of our neighbours. It can also lead to efforts among neighbourhood groups to help on a volun-

tary basis, by forming friendly associations for hospitals, for handicapped or ageing groups, or other needful work.

Possibly the greatest single cause of failure of the scheme to realise its full potential is the lack of trust and confidence, not only between the public and the workers in our social services, but between the workers themselves. There is a good deal of suspicion and antagonism between one group and another, leading to reduced efficiency of both. The causes for this are sometimes difficult to see, but it is possible to discern in all the situations, certain common factors.

Knowledge of Other People's Jobs

First is the fear that functions performed by one group are to be usurped by another, and that authority is likely to be undermined. Often social workers—and in this term I include workers in the fields of education, health and welfare—are abysmally ignorant of the training, qualifications and functions of their fellows in another department. They tend to regard as unjustifiable interference any effort on the other's part that might appear to overlap their own.

How is a better relationship encouraged?

A sound knowledge of the qualifications and aims of workers in the different branches can best be inculcated during training. This may threaten an extra burden on an already overloaded syllabus, but this is outweighed by the advantage to be gained in improved efficiency, and more economic use of personnel, which could result from mutual understanding and knowledge, leading to better co-operation.

Groups of students following different courses already meet to share lectures and studies, and to discuss their separate viewpoints. This system could be used much more widely. The teaching student finds great interest in the working of a public health department. Through an understanding of the functions of the school medical officer and health visitor, he is able to accept their visits, and use the school medical service intelligently when he takes a teaching post and is in charge of children. If medical students spend some time seeing the work of their future colleagues in the public health field, they will surely be better equipped to co-operate usefully, and to call upon the services available to them, when they are in practice.

Hospital nurses, who go out with their fellows, district nurses and health visitors, are most likely to have an understanding of the effect of home conditions on their patients, and to make use of the follow-up services provided by their public health department. Students in social science, future workers in the welfare departments, or as children's officers, almoners, probation officers, psychiatric social workers, all need as wide a knowledge as possible of each other, and of every other worker on the social scene. How else can they either carry out their own work adequately, or offer efficient co-operation with others?

During training, all these groups might easily meet, for joint lectures and demonstrations, and for discussion. This might be easier to achieve if nursing and health visitor trainings were more widely associated with local universities, so that training schemes could be worked out to allow for combined courses where practicable.

There is room for action at local level in bringing together workers in all fields, so that they may know and recognise each other as people. It is very much easier to discuss problems, or to seek help and co-operation from a group of people met and talked with, than from an impersonal signature to a letter, or a voice over the telephone. All members of the social team have their own professional bodies that hold meetings locally, and there is a great opportunity here for meeting and getting to know colleagues in other fields.

The medical officer has a responsibility in fostering good relationships between his own staff and the local general practitioners and hospital staffs. He can see to it that the general practitioner's function is in no way usurped by doctors and nurses in school health and maternity and child welfare services. General practitioners, on their part, are sometimes hyper-sensitive and aggressive towards their public health colleagues and refuse to co-operate in any way.

In many places, local authority clinics and school inspections are staffed by general practitioners, again an added call on a busy life, but very rewarding in its result of smooth team work, better understanding and service.

Pooling Knowledge

The co-ordinating committee is a well-established, efficiently functioning body in many parts of the country, and provides the meeting place for the different people concerned with a family or problem. Children's officer, probation officer, national assistance board member, the welfare worker and health visitor, and anyone else concerned with the family under discussion, can exchange views and let their colleagues know what is being done by each department.

Such co-operation avoids the duplication of visits that often leads to confusion and resentment in the family affected. It means that the family is considered as a complete unit, rather than a loose conglomeration of separate problems. So often, too, the individual efforts of single workers are vitiated through lack of knowledge, which might well be made known to them through co-operation with their fellows working on the case from a different angle.

Great efforts are being made to educate public attitudes to diseases such as cancer and tuberculosis, to mental illness and to the promotion of positive health. In all this, a concerted effort by all concerned in the fields of health and education, to devise the most suitable means for the most suitable audiences, would make more powerful the effect of the material available. The preservation of mental health, and the care and treatment of the mentally ill require a high degree of co-operation between general practitioner, hospital, psychiatric

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The Queen's Roll Examination

SUPERINTENDENTS and candidates have repeatedly complained that there was insufficient time to answer six questions in the Roll examination paper in three hours. This was the first paper in which only five questions had to be answered, including one compulsory question instead of two. As a result, few candidates found difficulty in finishing the paper.

Question 1

The description of the nursing care given to the elderly man was good on the whole. Candidates did not deal so well with the help given to his wife. Again many candidates spent too much time in describing the procedure for toilet routine, while omitting such details as care of the skin, mouth, hair, nails, etc.

The importance of preventing the elderly man from becoming bed-ridden was not considered by many candidates. Many elderly people suffering from acute bronchitis prefer to be helped out of bed to the commode, and are more comfortable sitting in an arm chair for part of the day.

Insufficient attention was paid to nursing details which would prevent complications such as pneumonia. Diet and ventilation were mentioned by most candidates, although the accurate keeping of reports and charts was often omitted.

With regard to help for the wife, insufficient mention was made of the importance of reserving her strength by seeing that she had adequate diet, and sufficient rest and fresh air. Assistance from the home help was suggested for housework and shopping, but few candidates mentioned enlisting help from children, friends and neighbours.

The importance of relieving the wife at night, when necessary, was omitted. If oxygen had been ordered for the patient, it would be necessary to ensure that a responsible person sat up to give this. The wife would definitely need advice on the disposal of sputum and the use of Miltherex.

A bed moved downstairs, with easy access to the kitchen, would lessen the distance the wife had to walk. Advice to her about the giving of medicines was not often remembered. Loans such as a commode, backrest, etc., and the financial help that might be needed, were included by many candidates.

Few patients considered the mental health of either the patient or his wife, and their spiritual needs were not mentioned. It seems that 'total nursing care' is not fully understood by all students.

Question 2

This question was popular with many candidates, and was quite well answered by most. They mentioned the responsibility of the nurse for the patient's insulin, diet, care of skin, feet, eyes and protection from infection.

Some candidates gave advice to the patient to carry sugar but did not explain the symptoms of threatened hypoglycoemic coma. Not all ensured that the patient carried a card stating that he was a diabetic, his name, address, and dose of insulin. Few suggested that he should link up with the British Diabetic Association or gave any other ways of helping him to live a normal life.

Some candidates did not encourage the patient to attend his doctor, or the hospital regularly.

Question 3

Only a few candidates answered this question. The important points which should have been made were:

(a) Wash off the jam with running cold tap water, wrap limb in clean towel and send for the doctor.

(b) Cover the eye and send the man to the doctor or hospital.

(c) Apply a dry dressing to the foot, and send the patient to the doctor or hospital.

(d) Turn off the gas, get the patient to fresh air, and carry out artificial respiration. Send urgently for the doctor and for the police who could help give artificial respiration.

Question 4

Most candidates who attempted this question had clear ideas of the advantages of nursing sick children at home, including the psychological benefits and the opportunities for health teaching. Many, however, had very hazy ideas as to when a child really needs to be transferred to hospital.

THE QUESTIONS

Time allowed for examination: Three hours—**five** questions only to be answered

PART I

Not more than three questions in all to be answered from this section. Question 1 is compulsory.

1. Describe the total nursing care of an elderly man with acute bronchitis, whose equally elderly wife wishes to keep him at home.
2. What are the responsibilities of a district nurse for diabetic patients?
3. What first aid treatment would you give for three of the following?
   (a) A housewife who has just scalded her forearm with hot jam.
   (b) A man with a foreign body in his eye.
   (c) An adult whose foot is pierced with a gardening fork.
   (d) An adult overcome by an escape of coal gas.
4. What do you think are the advantages of nursing sick children at home? Discuss the occasions when you think a sick child should be transferred to hospital.

PART II

Not more than three questions to be answered from this section.

5. In what ways do impaired hearing and failing sight affect the elderly? How can the district nurse help such persons and their families?
6. Which patients are most likely to be in need of national assistance? How could application be made for this and what kinds of assistance may be given?
7. You are attending a family of six, all of whom in turn have had influenza. What suggestions might be given to the mother about the convalescent period to restore the family to good health? The family income is limited.
8. Write short notes on three of the following:
   (a) Local Health Authorities.
   (b) Regional Hospital Boards.
   (c) Local Executive Councils.
   (d) Health Centres.

These are chiefly for special investigations for diagnostic purposes, for surgical intervention, when constant medical and nursing supervision are necessary, when there is mental illness or mental deficiency involving risk, and in the case of some infectious diseases in a large family. Poor home conditions, which can often be overcome by the help and ingenuity of district nurses, are seldom reason in themselves for admitting a child to hospital.

Question 5

The effect of impaired hearing and failing sight on old people themselves, was fairly well described. Most candidates showed little imagination as to how these conditions in old people might affect the people with whom they lived, possibly giving rise to much misunderstanding.

The testing of eyes and provision of new glasses was seldom thought of and hearing aids had very little mention. Welfare services and clubs for blind and deaf were not often remembered.

Question 6

Candidates remembered the need for national assistance for the elderly, the blind, the unmarried mother, the tuberculous, and others who need it for a long period. But those in need because of sudden emergencies, such as fire, floods or accidents, etc., were not mentioned. Help other than money, e.g. clothes, bedding, payment for residential accommodation, were seldom included.

Question 7

Most students gave advice on fresh air, sleep, holidays and days out. In teaching about diet, little thought was given to the price of food or to showing the mother how she could get the best value for her money and provide a nourishing, well-balanced diet.

Question 8

Nearly every examiner complained that candidates' answers were confused and hazy. They suggested that more teaching of factual information about these bodies is required.

Queen's Roll Examination Pass List

The following have been enrolled as Queen's Nurses from 1st June, 1959

Barnsley
Beech, Vera
Bristow, Grace

Birmingham
Bannister, Dorothy May
Jalland, Veronica Mary
McAteer, Gertrude Mary
Mosley, Margaret
White, Margot Noreen

Bolton
Carr, Frances Muriel
McGowan, Angela

Bradford
Bramley, Betty
Gillman, Mary
Rhodes, Sheila
Robertshaw, Joan Amelia

Brighton
Davies, Nancy Eileen Christiana
Holmwood, Elizabeth Rose
Lavers, Adelaide Olive
Ramsay, Cynthia Stephanie

Bristol
Flaherty, Rose Mary
Miller, Barbara Hazel
Phillips, Margaret

Brixton
Lehane, Mary Monica
Odusina, Sophia Adeoti

Bury
Gorman, Jane

Camberwell
Campana, Orsola
Hopkins, Kate Agnes

Coventry
Burns, Mary Josephine
McGovern, Annie Brigid

Croydon
Graham, Mary
Hermitage, Violet Irene
Lewis, Jean Rose
Lennon, Mary Kate

East London
Axten, Beryl Joan
Brandt, Lucille Agatha
Jamal Daya, Gulshan
Jones, Davina Margaret
Lennon, Grethel May
Potter, Gillian
Smith, Maureen Elizabeth
Tippen, Marion Elizabeth
Walters, Shirley Elizabeth
Welti, Rosine

Essex County
Bowden, Ida Evelyn Muriel
Crossfield, Jack William
Dixon, Lilieth Monica
Hamelberg, Susan Edith
Hodgskin, Mabel Eleanor
Lee, Vera Hilda
Malcolm, Patricia Ann
McManus, Ellen

Gloucester
Causley, Kathleen Elizabeth
Fullylove, Kate Elizabeth
James, May Winifred
Meager, Audrey Gertrude
Metcalfe, Mary Joan

Guildford
Dundas, Matilda Millar
Ross, Annie Elizabeth
Short, Joan Margaret
Webster, Helen Cecilia

Hackney
Beckford, Verna Barbara
Hollings, Bronia
Richens, Ann Dorling

Halifax
Grady, Margaret
Hodgson, Marjorie
Jordan, Mary Winifred
Levis, Josephine
Shaw, Mona
Southwell, Ann Lenore
Wolfenden, Cynthia Mary

Huddersfield
Littlewood, Jenny Margaret

Kensington
Beaton, Mary Alexanderina
Clare, Isoline
John, Elizabeth Ellina Mary
Lazaro Rivera, Carolina Teresa A.
May, Janet Shirley
Murray, Catherina
Smith, Ellen Margaret

Lancashire
Hamilton, Alison Elspeth Agnes
Leckey, Annie Mary
Lewis, Patricia Edith
MacDonald, Ross Roddy
McDermott, Winifred
Miller, Pauline
Patrick, Joan Mary
Richards, Peggy
Swinson, Monica
Szalonnas, Irén Maria

Leeds
Eastwood, Maureen
Sawdon, Jessie Maria

Leicester
Harrison, Jean Margaret
King, Valerie Anne
Parkin, Lilian Alice
Ward, Marie Lucille

Liverpool
Bateman, Hazel
Byrne, Margaret Mary
Gater, May
Jones, Meirionwen
Ledward, Joyce Eluned
White, Elizabeth Teresa

Manchester (Ardwick)
Hoban, Sarah

Manchester (Harpurhey)
Roberts, Ellen

Metropolitan
Cole, Pearl Monica
Dowthwaite, Jean Dorothy
John, Sherla Elitha
Page, Thelma Yvonne
Slade, Margaret Jean
Watts, Derek Stanley

Middlesborough
Bristow, Barbara Rose
Hoyle, Sylvia

North London
Bath, Pamela Lucilla
Lamb, Rhoda
McHugh, James

Nottingham
Brown, Joyce
Fleming, Catherine
Harrington, Sheila May
Plews, Gertrude Dinah
Ward. Pamela

Oxford
Carpenter, Audrey Muriel
Higgins, Joan Elizabeth
Lamberg, Brigitte Reinhilde
Preece, Phyllis Jane
Thompson, Ethel Marrion

Plymouth
Bradley, Beryl Angela
Budd, Mary Angela
Cornish, Winifred Agnes
Millman, Valerie Alice
Pleace, Marion Wendy
Rankin, Onah Patricia
Rowden, Robert Edgar

Portsmouth (Hilsea)
Knight, Pearl Sonia
Pedder, Hevina Grace

Portsmouth (Southsea)
Burckitt, Barbara Edith
Horten, Jean Sylvia Grace
Lennox, Dorothy May
Newman, Dorothy Amelia Denize
Powell, Megan
Robertson, Ethel May Penelope

Reading
Butler, Barbara May
Smyth, Eileen Constance

Rochdale
Davies, Florrie
Houton, Mary Rose
Whiteside, Joan
Wilson, John
Woodend, Jenny

Rotherham
Hale, Kathleen

St. Helens
Rimmer, Sheila

St. Olave's
Crawley, Barbara Joan
Davies, Virginia Olatunda Janet O.
Kinnear, Dora Mary
Nolan, Rita Mary

Salford
Powell, Dylys Laura Mary

Sheffield (Johnson Mem. Home)
Hatton, Delcia Christina
Kelly, Edna Louise
Phillipson, Joyce Mary

Sheffield (Princess Mary Home)
Chaloner, Constance
Millns, Mary

South London
Reed, Florence Louise
Teahan, William John

Surbiton
Ball, Jenda Drusilla
Dugmore, Joy Ivy
Green, Joan Margaret

Watford
Bush, Maisie Violet
Conlon, Edith Gwendoline
Dring, Maureen
Joyce, Rosanna
Slater, Janet Eileen
Winch, Eileen Margaret

Westminster & Chelsea
Beale, Maurine Willan
Thomas, Marion Elizabeth

Woolwich & Plumstead
Magnier, Mary Ellen
Medhurst, Iris Dorothy Mary

Aberdeen
Paterson, Mary Fraser
Thomson, Eleanor

Ayr
Veitch, Mary Laurie

Edinburgh
Carroll, Lucy
Corbett, Johan
Craig, Margaret Agnes
Erwin, Elizabeth Margaret Patton
Houston, Norah Margaret
Howatt, Irene May
Kajzarova, Helena
Lennon, Anna Cecela
MacKinnon, Allanina
MacKinnon, Annabella
MacLean, Barbara Jessie
Maclean, Marion
Marshall, Margaret Stewart
Paterson, Barbara Boitumelo
Simpson, Jessie Lockhart
Stevens, Judith Carolyn Jackson
Stewart, Iris
Wight, May King
Wilson, Edith Clark

Glasgow
Asiedu, Verona Louise
Clark, Elizabeth Jack
Hudson, Elizabeth
Kerr, Mary Johnston
McArthur, Mary Agnes
McCreadie, June Frances
Obinwa, Regina Ifeyinwa

Belfast
Beattie, Doris Maureen
Evans, Marlene Elizabeth
Fitzpatrick, Catherine Bernadette
Graham, Letitia Jane
Hamilton, Martha Elizabeth
Hill, Emily
Hunter, Emily Jane Laird Buchanan

Londonderry
O'Donnell, Mary
Scott, Elizabeth

Dublin
Gilligan, Carmel Berenett
McGrath, Mary Elizabeth
McHugh, Nora Mary
Scanlan, Mary

HEVER CASTLE

The Times photograph

A Garden of Many Surprises

THREE and a half acres of flowers of every colour scent and shape again presented a wonderful spectacle at the Chelsea Show this year. And in the open, outside the huge marquee, the gardens laid out included a delightful one with rhododendrons and azaleas from Exbury, in Hampshire, a garden which we looked at with particular interest since the grounds at Exbury are open for The National Gardens Scheme. The wide grass paths between the shrubs, reminiscent of the grass rides in the Hampshire garden from which they had come, showed off the shrubs to perfection.

In all parts of the Show the Gardens Scheme found old friends, people who open their gardens or nurseries for the Scheme, and others who advertise in the guide book.

At the National Gardens Scheme stand people stopped to buy the guide. To many of them it was already familiar but to many more it brought the promise of a pleasure they had not realised was possible—that of visiting other people's private gardens. Many visitors from overseas also bought the book and stopped to discuss how best to fit in visits to gardens during their time in this country.

The gardens at Hever Castle will be opened for The National Gardens Scheme on the last Sunday in August. The castle dates back to the 13th century and was at one time the home of Anne Boleyn's father. In front of the castle stand the topiary specimens pictured above; beyond this moated part of the garden, attractive at all times of the year with simple flowers, are magnificent gardens full of surprises. From the front of the castle a walk leads to the Italian garden with its grassy rectangles, pergola and grotto and a remarkable array of statuary, columns, sarcophagi and sacrificial altars set out among flowers and shrubs. There is an inner garden to enjoy, and the piazza with its great Italian fountain bowl. A stroll round the 32-acre lake leads one to a fine avenue of horse chestnuts and back to the moat between the buttressed yews and the grey castle walls.

Copies of the guide book, " The Gardens of England and Wales Open to the Public " price 2*s* are obtainable from booksellers, or (plus 6*d* for postage) from The Organising Secretary, The National Gardens Scheme, 57 Lower Belgrave Street, London, S.W.1.

Applications to hire the film, "The Gardens of Britain" should be sent to Sound-Services Film Library, Wilton Crescent, London, S.W. 19. The cost of hiring the film is one guinea.

Letters should be addressed to:
The Editor, District Nursing, 57 Lower Belgrave Street, London, S.W.1.

Some Call Me Sister

As I had the privilege of acting as nursing adviser when the documentary *Some Call Me Sister* was produced, may I try to clarify a few criticisms for my colleagues.

In reply to Roll No. 16011: It was a documentary but not a film; only a very small part of it was filmed and interspersed. It was live acting, fourteen sequences to be put into three-quarters of an hour. Had it been two hours, the procedures and techniques may have been shown more perfectly.

Until the actual hour of transmission it had taken much longer than three-quarters of an hour, and when it had to be produced in that time, the camera men had to wheel their huge apparatus around more quickly. Instead of seeing a gowned, capped and masked Nurse Charles, with table, towels, tins, thermometer, jar, etc., well laid out, there was just a voice: "Relax, relax". Every moment is timed to the split second and also to the measurement of an inch. A television star must work within a measurement of three inches when going through a door, folding a coat, attending to a patient.

Nurse Charles wore her uniform well, she managed a non-touch technique, she remembered to turn up her apron, fold her coat, take off her watch; and she never listened to gossip. She sat down for a general nursing care for Tom Lee. If she had not done so, the cameras could not have got her head in the picture. The patient did not have his shirt off to begin with (he did later you noted) because he had something to say, a part to act: how could he, with his shirt being taken off?

The story was written after the author, Duncan Ross, had spent some days in a rural area observing the work of the Queen's nursing sister. It showed how diverse this work can be in a rural area with generalized nursing duties, and how different from that of general nursing only in a large city. It also showed why district training is essential.

There was a great effort towards accuracy—three weeks concentrated practice, learning of the script, etc. There was a sincerity throughout the whole of the portrayal and a wonderful team spirit. Always the producer's word was final and never questioned. Nurses are not the only ones to accept discipline!

In a letter after the production Nurse Charles said that she hoped she had not embarrassed any Queen's nursing sister by giving the authority of television to any of her mistakes or errors.

Do not ever think that any other than an actor or actress trained for the work could take the part for a television performance. It is a most exacting duty, with the same movement to be enacted time after time, and then finally with no audience to be receptive or to give applause.

How pleased I was to be the "real thing" and to have the privilege of carrying out the nursing duties, instead of trying to act them for thousands of unseen people to watch and, very naturally, to criticize.

Catherine Dolton

My colleagues, patients, their friends and neighbours, also a cross-section of other people, all agree that the film *Some Call Me Sister* was most unrealistic. We hoped the film would help the appeal, but question whether it has done so. We would appreciate a good film, showing our true work and conditions.

Queen's Roll No. 11705

I too viewed the T.V. feature *Some Call Me Sister* and unlike your correspondent Queen's Nurse 16011, who found "no connection between the film and what she knows or considers is the work of a rural nurse", I thought it conveyed a very fair portrayal of generalized work in a semi-rural area similar to that in which I have the pleasure to serve.

Certainly I have found no one among patients or colleagues who considered it "unrealistic".

Nothing is idyllic all the time, but the highlights of nursing, surely a part of any nurse's experience, are bound to be sandwiched between periods of dull routine and near drudgery, as anyone who has the least experience of illness in any form will be well aware.

Have a heart, No. 16011 !

Would you have the B.B.C. do us the disservice of depicting in painstaking lengths the most harrowing and boring moments of our work, ignoring the fact that viewers pay to be entertained and interested, if not amused?

There appears to be a note of wistful envy about our colleague's letter.

Does she think the grass is greener on our side of the fence?

Having done my stint in the heart of our largest city, I quite agree, in all senses!

Let her brave the thistles and nettles then, in the form of broken nights and problematical off-duty and do her "midder", joining us in the rural community.

I am not in a position to know statistics relating to the aspects of work that your correspondent is asking, but I guarantee that if she follows my advice, she will indeed be disinclined to pursue any ambitions she may previously have held in returning to be assistant administrator in a city home.

Dorothy A. Last
Bury St. Edmunds, Suffolk.

Thanks

May I through the courtesy of your journal send my most sincere thanks to all Queen's superintendents and nursing sisters in Scotland for their amazing kindness, generous presentation party and gift of a purse/wallet and cheque for £200 on the occasion of my retirement as superintendent of the Scottish Branch of the Institute.

I am sorry I am unable to write to each sister individually, but I do hope that sometime or other each will visit this lovely Cotswold village where I am staying with my friend Miss Chamberlayne, and where there will always be a welcome. **Phyllis Bennett**
Brundall, Burton-on-the-Water,
Cheltenham.

May I through the courtesy of your journal, express my gratitude to all who made my four month's stay at the Oxford training home for Queen's District Nurses such a very happy and enjoyable experience, as well as giving me such excellent training.

Britta Lamberg
Langley, Buckinghamshire.

MAY I through the courtesy of your columns express my gratitude for the opportunity of hearing of the wonderful work done by the National Spastics Society.

A talk given by Miss Shirley Keene, herself a spastic, and a fluent and interesting speaker, added to my scant knowledge of the subject. A coloured film was also shewn. Both speaker and film deserve a wider audience.

K. Dennington
Upper Beeding,
West Sussex.

Queen's Nurses

Personnel changes 1st to 31st May, 1959

APPOINTMENTS

Superintendents, etc.

Newby, M. E., Lancs.—Asst. Supt. Southward, M. M., Liverpool—Asst. Supt.

Nurses

Bacon, M. J., Cheshire. Barker, B. A., W. Sussex. Barker, M. (Mrs.), Bucks. Beckett, A. (Mr.), Surrey. Bishop, S. K., Berks. Buxton, D. J., Somerset. Case, J. A., Shoreditch & Bethnal Green. Chaplin, D. B., W. Sussex. Collier, E. E., Lancs. Downing, H. A., Bucks. Downing, J. A., Middx. Fitzpatrick, V. (Mrs.), Lancs. Hallam, M., E. Riding. Inglefield, H. M., Surrey. Lamberg, B. R., Bucks. Lavin, M., Beds. Lawrence, M. E., Bucks. Moore, K., Leics. Neale, M. E., Glos. Pierce, B. L., Berks. Rennie, J. H. (Mr.), Rotherham. Salmon, C. A., Surrey. Woodrow, B., Glos.

REJOINERS

Burton, E. I. (Mrs.), Lancs. Carter, B. (Mrs.), Liverpool. Oliver, M. E. (Mrs.), Cornwall. Weedon, E. A. (Mrs.), Middlesbrough. Wright, D. L. (Mrs.), Eastbourne.

LEAVE OF ABSENCE

Day, P. E. P.—Midwifery trg. Viveash, E. M.—H.V. trg.

RESIGNATIONS

Kenyon, B., St. Olave's (Asst. Supt.)—H.V. post. Blandford, V. V. R., Kensington—Other work. Brinn, P. B., Herts.—Marriage. Brown, M., Herts.—Domestic reasons. Burt, M. N., Croydon—Other work. Cott, E., Liverpool—Work in school. Cowan, A. F., Warcs.—Retirement. Evans, C. M., Brighton—Other work. Evans, E., Huddersfield—Ill health. Farrer-Hare, J. L., Essex—To go abroad. Hargreaves, M., Lancs.—Full time health visiting. Hillman, E. A., Somerset—Marriage. Hunnable, E. A. P., Essex—H.V. trg. James, K. A., Worcs.—Domestic reasons. Johnson, E., Cheshire—Other work. Keegan, I. C., Essex—Going to Newfoundland. May, D., Essex—Domestic reasons. McKendry (Mrs.), Co. Antrim—Marriage. Mills, A. C., Essex—H.V. trg. Murphy, B., Co. Antrim—Going to Canada. Newell, M. B. E., Co. Antrim—Marriage. Osborne, J. B., W. Sussex—Other work. Passmore, C. B. (Mrs.), Essex—Domestic reasons. Pickering, T., Somerset—Private nursing. Ross, E., N. London—Missionary work. Thompson, M. A., Bradford—Other work. Tyman, M., Leics.—Post abroad. Vigar, J. W., Brighton—Other work. Weardon, G. (Mrs.), Lancs.—Domestic reasons.

Scottish Branch

APPOINTMENTS

Nurses

Corbett, J., Inverkeithing. Houston, N. M., Kinghorn. Johnstone, M. C., Polbeth. McKelvie, E. D., Newtyle. MacKinnon, A., Stoneykirk. MacLean, B. J., Old Meldrum. Matthew, K., Coldingham (temp.). Simpson, J. L., Kilsyth. Stevens, J. C. J., Armadale. Stewart, I., Kirkpartick Durham.

REJOINER

Gordon, S. D. (Mrs.), Glasgow (Strathbungo).

RESIGNATIONS

Bain, A., Kinghorn—Work abroad. Bennett, P., Superintendent, Scottish Branch—Retired. Brisbane, J., Bathgate—Marriage. Davie, M., Glenurquhart—Marriage. Fairweather, M. M., Monifieth—Home reasons. Hutton, M., Glasgow (Govan)—Marriage. Kerr, B., Glasgow (Springburn)—Marriage. MacEachin, J., Morar—Retired. Macphee, C., Clydebank—Home reasons. Macrae, M. M., S. Snizort—Marriage. MacRaild, M. M., Cowdenbeath—Marriage. MacVicar, J. M. Luing—Other work. Marjoribanks, A. L., Late of Berwickshire—Other work. Marshall, E. H., Thornton—Other work. Watt, R. G., West Calder—Other work.

Personnel changes 1st to 30th June, 1959

APPOINTMENTS

Superintendents, etc.

Brandish, M. N., N. Riding (Supt. N. O.). Drew, A. E. L., E. London (Supt.). Elliott, P., Middlesbrough (Asst. Supt.). Guttman, C. E., Essex (Asst. Supt.). Plant, M., Cheshire (Asst. Supt.). Sammonds, D. M., Surrey (Asst. Supt.). Schadek, G. A., Herts. (Div. N. O.).

Nurses

Ames, H. I., Hants. Cooper, R. M., W. Sussex. Davey, O., Surrey. Hicks, P. A., Glos. Hill, M. F., W. Sussex. Johns, E. E., Swansea. Lloyd, A. M., Birmingham. Meredith, M. G., Glos. Meyer, I. V., Hove & Portslade. Moores, E., Lancs. Moss, A. P., Stockport. Needle, I. A., E. Sussex. Newlands, F. M., Birkenhead. Porter, A. B., Cheshire. Reeves, G. (Mrs.), Glos. Reynolds, M. (Mrs.), Warcs. Szubynski, C. E., W. Sussex. Thomas, N. E., Canterbury. Whelehan, T. (Mr.), Exeter. Williams, D., Cheshire. Wood, M., Somerset.

REJOINERS

Guest, D., Lincs., Holland (Asst. Co. Supt.). Roberts, M. (Mrs.), Croydon (1st Asst. Supt.). Brooker, A. M. (Mrs.), W. Sussex. Davies, C. M., Dorset. Holyoake, P. A., Norfolk. Howards, B. (Mrs.), St. Helens. Morton, C. (Mrs.), Caerns. Palmer, A. G. O., Somerset. Phelps, E. A., Gloucester. Sehnke, O. J. (Mrs.) Lincs., Holland. Swift, J. (Mrs.), S. London.

LEAVE OF ABSENCE

Gethen, M. E.—Extension of leave. Glasscock, G. M. (Mrs.)—H.V. trg. Hulks, R. P.—H.V. trg. Hutchinson, J. R. A.—H.V. trg. Town, D.—Midwifery trg. Watkins, J.—H.V. trg.

SECONDMENT

Case, J. A.—Work with Grenfell Assn. Kratz, C. R.—Supt., Dar es Salaam D.N.S. Macaulay, M. S.—Work with Dar es Salaam D.N.S.

RESIGNATIONS

Bailey, P. M. (Mrs.), Glos.—Domestic reasons. Barrett, N. (Mrs.), Rochdale—Domestic reasons. Cain, E., Bury—Hospital post. Cave, R., Liverpool—Domestic reasons. Clohessy, M. M., Warcs.—Other work. Conlon, B. T., Halifax—Going abroad. Davis, M. A., Woolwich—Domestic reasons. Deutsch, K. E., Isle of Ely—Hospital post. Fraser, C., Shoreditch—Domestic reasons. Garbutt, E. (Mrs.), Halifax—Retirement. Hamilton, A., Stockport—Hospital post. Harris, J. (Mrs.), Reading—Domestic reasons. Henrich, C. J., Isle of Ely—Hospital post. Houston, E., Hove—Going abroad. Lee, E. M., Beds.—Marriage. McGill, J. M., Belfast—Going abroad. Scott, M. N., Metropolitan—Midwifery trg. Stephens, M. E. (Mrs.), Bucks.—Marriage. Warren, M. R., Norwich—Marriage. Wilkinson, A. A., Middlesbrough—Marriage.

Scottish Branch

APPOINTMENTS

Superintendents, etc.

Bell, H. T., Stirlingshire (2nd Asst. Supt.). Milne, E., Glasgow (Strathbungo) (Asst. Supt.).

Nurses

Clark, J., Alloa. Currie, C. A., Morar. Edgar, F. B., Kilsyth. Lea, M., Rhynie. Macdonald, J., Glasgow (Anniesland). Macfarlane, G. S., Stenhousemuir. Macfarlane, M., Stirlingshire C.R.N. Mackenzie, E., Fochabers. MacKinnon, P., Stirlingshire C.R.N. Wight, M. K., Arbuthnott (Temp.).

REJOINER

Christie, B. S., Dunoon.

RESIGNATIONS

Bethune, M., Birnie—Marriage. Buchanan, J., Castlebay—Other work. Bulloch, C., Moray & Nairn (Supt.)—Retired. Currie, C. K., Alloa—Work abroad. Fraser, O. M. A., Moray & Nairn C.R.N.—Marriage. Murray, M. K. (Mrs. Cunningham) Glasgow (Dennistoun)—Work abroad Nicholson, J. I., Johnstone—Marriage. Ross, M., Dunfermline—Other work. Stirrat, M. C., Glasgow (Dennistoun)—Home reasons. Tocher, M. J., St. Fergus—Other work. Wallace, B. B., Strontian—Marriage. Wood, M. T. L., Edinburgh—Other work.

TRANSFER TO ENGLAND

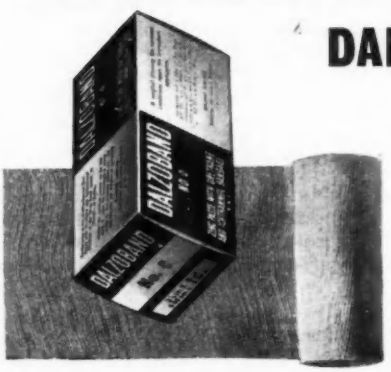
Drew, A. E. L., Dunbeath. Lavin, M., Kilsyth.

Ambulatory treatment of the ulcerated leg...

Of proved success in pressure bandaging Lestreflex Diachylon Bandage alleviates pain, promotes rapid healing. It is innocuous to newly formed tissues and leucocytes and can be used on sensitive patients with minimal risk of plaster idiosyncrasy.

LESTREFLEX
ELASTIC DIACHYLON BANDAGE

▲ Samples and literature from DALMAS LTD., Dept. No. D.L.1., JUNIOR STREET, LEICESTER ▼



DALZOBAND *ZINC PASTE BANDAGE*

Never losing its moistness, Dalzoband is always ready for use, never becomes uncomfortable with wear. Formulations to meet all skin conditions associated with varicose ulcer.

No. 2:	Zinc Paste Medicament.
No. 2x:	Extra moist.
No. 3:	Zinc Paste and ichthammol 2%.
No. 3x:	Extra moist.
No. 3EM:	Extra soft.
No. 4:	Zinc Paste with urethane 2% and ichthammol 2%.
No. 5:	Zinc Paste with urethane 2% and calamine 5·75%.
No. 6:	Zinc Paste with coaltar 3%.
No. 6x:	Extra moist.
No. 20:	Zinc Paste with iodochlorhydroxyquinoline 1%.

the above bandages available on E.C.10.

The Association of District Nurses

£1,000 FOR CENTENARY

A THOUSAND pounds was raised at the garden party arranged by the Association of District Nurses at Fulham Palace on 30th May. After the deduction of expenses, it is expected that £450 will be handed over to both the centenary appeals of the Queen's Institute and of the Central Council for District Nursing in London.

'The day' worked for and looked forward to for so long, dawned cloudy, and those with faith in the B.B.C. spoke of showers and bright periods. At lunch time anxious eyes were cast to the sky, an ominous steely grey. But by a quarter past two it had lightened, and the last-minute touches to stalls were made in a more cheerful atmosphere.

The strains of a military band came close, and at half past two Miss Kay Hammond appeared, accompanied by the Bishop of London, the Mayor and Mayoress of Fulham, Miss L. J. Gray and Miss N. M. Dixon (president and chairman of the Association of District Nurses), Miss H. McKeague (Central Council for District Nursing in London) and the chairmen of the Metropolitan branches of the Association.

The formal opening was soon over, and Miss Hammond started a tour of the stalls. She and the other visitors had a wide choice of ways of lightening their purses. Selling was brisk. There were plants and flowers (Metropolitan Federation); a holiday stall (West Sussex); toys (Leytonstone); cakes and sweets (headquarters); White Elephant (East London and Hackney); and a 'blue' stall displaying a wide range of articles in many shades of blue (Metropolitan and North London.)

These were not the only attractions. Strolling between the stands, one was invited to guess the weight of a cake, to name a doll, to find the Treasure or, at the bottle tombola, to "win a bottle of whisky for two bob." Many tried, and the lucky winner, returning to his wife and child at the back of the crowd, was greeted with an incredulous "Wherever did you get that?"

At intervals during the afternoon, the crowds at the stalls set in a semi-circle round the garden, drifted to a roped-off arena in front of the palace. Here, pupils of the Doreen English Stage School gave a display which included a ballet trio in traditional frou-frou skirts; folk dances; "Where are you going my pretty maid?" sung by five pretty maids, squired by two solemn six-year-old cavaliers; and a Turkish-style comedy act cleverly danced by three boys, one tall, one short, and one in-between.

Miss Hammond on tour — *Nursing Mirror photograph*

The dancing was followed by a canine obedience demonstration given by members of the Kent Alsatian Training Society. The way in which the dogs obeyed commands from their owners, as well as the ways they occasionally disobeyed (to be fair, usually the very young dogs) drew delighted oohs and ahs from the audience.

Between these demonstrations, the band of the Royal Engineers (T.A.) played from the stand in the centre of the lawn—airs from Gilbert and Sullivan and *My Fair Lady* suitable to the occasion. The ice-cream and soft drinks booths were well patronised but judging from the queue district nurses and their friends still prefer tea.

Many flower-lovers visited the marquee housing the display of floral decorations, a dim oasis of quiet and beauty amidst the fun of the fair.

At six o'clock the Morris dancers made their appearance, a gay sight in their motley. A mounted (on a hobby-horse) policeman kept the crowds at bay as the team danced its way round the lawn. After the Morris dancing came the announcements of prize winners in the raffles and of the lucky programme numbers. These were 0684, 3626, 2887, 0818, 5055.

CENTENARY DINNER

The Centenary Dinner will be held at the Adelphi Hotel, Liverpool, at 7 p.m. on Saturday 10th October 1959.

Applications for tickets—price 27s.6d. (excluding wines)—should be sent with remittance to: G. Tildsley, Esq., Hon. Treasurer, Liverpool Branch, Association of District Nurses, 130 Dentons Green Lane, St. Helens, Lancashire.

Hotels

Adelphi Hotel, Ranelagh Place, Liverpool
The Exchange Hotel, Tithebarn Street, Liverpool 2
The Stork Hotel, Liverpool.

For details of charges apply direct to hotels.

The meeting of the **Executive Committee** will take place at the Central Home, 1 Princes Road, Liverpool, on the **same day** Saturday 10th October at 2.30 p.m.

MIDLAND

IN her annual report presented to the annual general meeting the honorary secretary, Miss Taft, said that membership of the branch was thirty-six.

The honorary treasurer, Miss Beaton, reported a credit balance of £102 12*s* 5*d* with the travelling scholarship fund amounting to £117 3*s* 10*d*.

Miss I. D. Irven gave a very interesting talk on 'District Nursing in Kenya.'

D. E. M. Taft

Nursing Mirror photograph

Superintendent of Scottish Branch Retires

A HAPPY and representative gathering of Queen's Superintendents from all over Scotland met in the Adam Rooms of the George Hotel, Edinburgh, on 27th May. The occasion was a presentation party for Miss P. Bennett, superintendent of the Scottish Branch of the Institute, who retired on 31st May. Miss Bulloch, County Nursing Officer of Moray and Nairn, and Chairman of the Association of Scottish Queen's Superintendents presented a cheque for £200 and a combined purse/wallet to Miss Bennett.

Miss Bulloch referred to Miss Bennett's services to the Institute and to her kindness and easiness of approach which meant so much to both superintendents and nurses. On their behalf she wished Miss Bennett a very happy retirement, blessed with good health.

Miss Bennett thanked the superintendents and nurses for their wonderful gift. She said she felt it was not only a personal tribute but also a tribute to the service. Her greatest pleasure during her term of office had been meeting the nurses at work on their districts.

Miss Bennett thanked the superintendents for their loyal support, which had meant so much to her during the past seven years and without which she could not have carried our her work. She hoped her successor would have the same support, kindness and co-operation which she had experienced during her term of office.

Travel Bursary Winner

MISS **Katherine Mary Jones**, S.R.N., S.C.M., H.V., Q.N. and Industrial Nursing certs., has won the first *Nursing Times* travel bursary of £5,000.

Education Officer at the Birmingham Centre of Nursing Education of the Royal College of Nursing, Miss Jones is also a member of the Birmingham Area Nurse Training Committee.

Applicants were invited to submit their own ideas of a project which would contribute something of value to the development of the nursing profession of this country on their return. They were also asked which country, or countries they wished to visit.

Miss Jones wishes to investigate the training of teachers for the courses of practical nurses (corresponding to our state enrolled assistant nurses) in Canada and the United States.

CLASSIFIED ADVERTISEMENTS

Advertisements for this section can be received up to first post on the 2nd of the month for publication on the 10th. They should be sent direct to: District Nursing, 57 Lower Belgrave Street, London, S.W.1. Telephone Sloane 0355.
Rates: Personal, 2½d. per word (minimum 12 words, 2s. 6d.): all other sections, 3d. per word (minimum, 12 words 3s.)
Displayed Setting: 17s. 6d. per single column inch.

BUCKINGHAMSHIRE COUNTY COUNCIL

Applications are invited for the following posts. Present holiday arrangements honoured.

Bletchley—One District Nurse-Midwife. Modern house available. Furnished or unfurnished.
Motorist or willing to learn.

Butlers Cross (Aylesbury)—One Area Relief Nurse/Midwife from beginning of October 1959. House available. Furnished or unfurnished. Car driver essential.

Farnham Royal (Slough)—One Area Relief Nurse/Midwife. Modern house available. Furnished or unfurnished. Motorist or willing to learn.

Haddenham—One District Nurse/Midwife. House under course of erection. Furnished or unfurnished. Car driver essential

Langley (Slough)—One Area Relief Nurse/Midwife. Modern house available. Furnished or unfurnished. Car driver or willing to learn.

Ravenstone (nr. Olney)—One District Nurse/Midwife/Health Visitor for nine months' relief duties from September 1959. Car driver essential. Accommodation provided.

Queen's District Training Courses—State Registered Nurses with the S.C.M. Certificate for four months' courses arranged by the Queen's Institute of District Nursing. Candidates undertake to work in Buckinghamshire for a period of one year on completion of training. Courses commence 1st September 1959 and 1st January 1960.

Further particulars and application forms obtainable from County Medical Officer, County Offices, Aylesbury.

COUNTY BOROUGH OF SOUTHEND-ON-SEA

Home Nursing Service—
Male District Nurse

Applications are invited for appointment as District Nurse (Male).

Must be S.R.N. District training an advantage.

Salary and conditions of service in accordance with the Award of the Nurses and Midwives Council of the Whitley Councils for the Health Services.

Housing accommodation will be made available if required, and a car allowance is payable.

The candidate appointed will be eligible to apply for appointment as a relief Duly Authorised Officer in respect of which an additional payment of £75 per annum is made.

Forms of application can be obtained from the Medical Officer of Health, Municipal Health Centre, Warrior Square, Southend-on-Sea, to whom they should be returned within three weeks of the appearance of this advertisement.

ARCHIBALD GLEN
Town Clerk

BRECONSHIRE COUNTY COUNCIL

(In membership with the Queen's Institute of District Nursing)

Public Health Department

Applications are invited for the following posts:—

(1) **District Nurse/Midwife/Health Visitor/School Nurse** for the following areas:
  (a) Brecon Rural (Merthyr Cynog, etc.)
  (b) Beulah area.
  (c) Llanwrtyd Wells area.
(2) **District Relief Nurse/Midwife** for Brecon Crickhowell areas.

Applicants must be S.R.N. and S.C.M. and for the combined posts including Health Visiting should also hold the Health Visitors Certificate.

Scholarships are offered for training as Queen's Nurses and/or Health Visitors.

A car is essential in each appointment. (A scheme for the assisted purchase of a car is available up to 100% loan, or a car can be provided by the Authority). Whitley salary and conditions of service.

The District Councils do all they can to see that the nurses in their areas are provided with houses, and in Brecon it is possible that the house already allocated to a nurse will become vacant shortly.

Forms of application and further particulars can be obtained from the County Medical Officer, Health Department, Watton Offices, Brecon, and should be returned within two weeks of the appearance of this advertisement.

CITY OF BATH—HEALTH DEPARTMENT

Municipal Midwife

Applications are invited from qualified midwives for the appointment of Municipal Midwife to a district in the City.

The post is superannuable, subject to satisfactory medical examination, and the Whitley Council's salary and conditions of service apply. Housing accommodation will be provided.

Further particulars and forms of application from the Medical Officer of Health, Sawclose, Bath.

Guildhall, Bath.
30 July 1959

JARED E. DIXON
Town Clerk

NORFOLK COUNTY COUNCIL

Applications are invited for vacancies in the undermentioned areas:—

District Nurse/Midwife/Health Visitor (preferably with Queen's and H.V. Certificate or willing to train)
  Hilgay, nr. Downham Market— Unfurnished house.
  Hockham, nr. Thetford—Unfurnished. house.
  Long Stratton, South Norfolk—Second nurse. Furnished accommodation.
  Tacolneston—Possibly unfurnished house.
  Terrington St. John, nr. King's Lynn—Furnished accommodation—house later.

Full-time Midwife (S.R.N., S.C.M., and preferably with Queen's Certificate).
  King's Lynn—Unfurnished house.
  Watton—Furnished accommodation—house being built.

Facilities available for Health Visitor and Queen's Nurse training with a view to generalised duties.

Staff needed for relief duties—holidays or longer periods.

Whitley Council salaries and conditions of service.

Successful applicants can use their own cars (loans available for purchase) or cars can be provided. Consideration will also be given to supplying furniture, if required.

Application forms from County Medical Officer, 29 Thorpe Road, Norwich.

SALOP COUNTY COUNCIL

Assistant Superintendent Nursing Officer

Applications invited from experienced Nurse/Midwives, duly qualified as Supervisors, for a further superannuable post of Assistant Superintendent Nursing Officer. Experience in Home Nursing, Midwifery and Health Visiting essential. Possession of car an advantage. Salary according to Whitley Scale.

Application forms, further particulars and conditions of service, may be obtained from the undersigned to whom applications should be submitted.

T. S. HALL
County Medical Officer of Health
County Health Office
College Hill, Shrewsbury

COUNTY BOROUGH OF WEST HAM

(Within easy reach of Central London)

Health Services

(Affiliated to Queen's Institute of District Nursing)

Applications invited for following vacancies:—
(*a*) **Domiciliary Midwife** (S.C.M. and preferably S.R.N.).
(*b*) **District Nurse Midwife, S.R.N.** (preferably with district training), and S.C.M.
Furnished Flatlet Available. Car owner/driver preferred, for which mileage allowance is payable. A scheme for assisted motor car purchase is in operation.

Whitley Council salary and conditions of service, plus allowance for Part II training of Pupil Midwives.

Application forms (and further particulars) from Medical Officer of Health, 225 Romford Road, Forest Gate, E.7, to whom application should be made within 14 days of the appearance of this advertisement.

Other Advertisements on p. 104

CUMBERLAND COUNTY COUNCIL

(Affiliated to the Q.I.D.N.)

District Midwives for Whitehaven—Two required. Suit friends. Accommodation to be arranged.

Health Visitors for Workington—Two required. Small unfurnished flat available for one.

District Nurse/Midwives for Egremont—Double district. Suit friends. Furnished house provided.

District Nurse/Midwife/Health Visitor for

(*a*) **Greystoke** (Ullswater area)—Furnished cottage available.

(*b*) **Crosby** (Maryport)—Rural area near Solway coast. New house available furnished or unfurnished.

(*c*) **Ireby**—House available furnished or unfurnished.

(*d*) **Bootle** (near Millom)—House available furnished or unfurnished.

Cars will be provided for all the above appointments.

Queen's District Training—Applications are invited from Nurses S.R.N., S.C.M., wishing to work as district nurse/midwives in Cumberland. Arrangements can be made for them to take four months training at an approved Queen's Nurses' Training Home.

Application forms from County Medical Officer, 11 Portland Square, Carlisle.

HAMPSHIRE COUNTY COUNCIL

Home Nursing and Midwifery Service

Weyhill, nr. Andover—District nurse/midwife required. House provided.

Bramley, nr. Basingstoke—Two district nurse/midwives required to share bungalow.

Cars provided or allowance given for use of own car. For further particulars and forms of application, apply: The County Medical Officer, The Castle, Winchester.

WESTMORLAND COUNTY COUNCIL

Nursing Services

Arnside—District nurse/midwife/health visitor required for this small coastal holiday resort. House and car provided.

Kendal—Two district nurse/midwife/health visitors required. Suitable for friends. New house and cars provided. For further details apply to County Medical Officer, County Hall, Kendal.

ROYAL BURGH OF AYR

Superintendent of Home Nursing Service

Applications are invited for the above-mentioned resident appointment which entails the superintendence of the Home Nursing Service and Nurses' Home and the training of Pupil Queen's Nurses.

Candidates must be registered General Nurses, State Certified Midwives and should hold the Health Visitor's Certificate and the Certificate of the Queen's Institute of District Nursing

The salary scale is that provided by the Nurses and Midwives Whitley Council for a Training Home with 9–15 nurses. The successful candidate will be required to pass a medical examination for superannuation purposes.

Applications, giving full particulars of experience and qualifications and the names and addresses of three referees should be lodged with the undersigned not later than 14th September 1959.

R. L. LEASK, Medical Officer of Health, Health Department, 32 Miller Road, Ayr.

SALOP COUNTY COUNCIL

Applications are invited for the undermentioned vacancies in the County of Salop

Health Visitors

Oswestry Urban area.
Wellington Urban area.
Shrewsbury Urban area.
Newport area for October next.
Dawley area for September next.

District Nurse/Midwives

Donnington double district.
St. Martin's district.
Tibberton district.
Wem district.
Clungunford district for September next.
Relief for Whitchurch area.
Relief for Ludlow area.
Relief for holiday periods.

Application forms and further particulars obtainable from: T. S. Hall, County Medical Officer of Health, County Health Department, College Hill, Shrewsbury.

SOUTHWARK, NEWINGTON & WALWORTH D.N.A.

Assistant Superintendent required. Staff approx. 20—Modern well equipped centre —furnished or unfurnished accommodation available. Apply: Dep. Gen. Supt., Q.I.D.N.

HOME CARE OF SICK CHILDREN

Queen's nurses whose names are on the Sick Children's Register and who are interested in taking part in a Home Care Scheme for Sick Children, are asked to write to the Deputy General Superintendent, Q.I.D.N., 57 Lower Belgrave Street, S.W.1.

PRIZE OFFER

A copy of Cecil Woodham-Smith's *Life of Florence Nightingale* will be presented to anyone recruiting ten new subscribers to **District Nursing** within three months of the appearance of this notice.

A holiday for two or three weeks is offered at Champney House, Pembury Road, Tunbridge Wells, by John E. Champney's Trust. The Home is endowed by the Trust so that the charge is reduced to 4½ guineas a week. Teachers, Nurses, Ministers of Religion, Social Workers and other persons in active life, especially younger people, are invited to apply for particulars to the Warden at the above address.

QUEEN'S NURSES' BENEVOLENT FUND

Founded in 1913 *by Queen's Nurses, for Queen's Nurses*

Minimum subscription FIVE SHILLINGS a year.

OBJECT—To assist financially colleagues who have to give up work owing to illness.

APPLICATIONS for financial assistance may be made for a GRANT, after three consecutive subscriptions previous to going off duty owing to an illness of short duration have been paid, and after salary rights have been exhausted. *OR*

AN ANNUITY, after five consecutive subscriptions have been paid up to time of going off duty, when the illness involves resignation from District Nursing, and the applicant is unable to undertake other work.

SUBSCRIPTIONS should be sent to Miss Ivett, Lancastria, Boyndon Road, Maidenhead, Berks, from whom further details can be obtained.

An Annual Report, with a renewal notice, is posted direct to all subscribers each year.

The Social Services and How to Use Them

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social worker and almoner, so that the patient and his family may be upheld and encouraged by the combined effort of a team agreed in its methods and aims.

Old people, too, benefit enormously from the care of a fully united team, with general practitioner, district nurse and health visitor working together, and calling on other organisations, statutory and voluntary, to assist them in maintaining health and happiness, at home as long as possible, and then in a home or hospital.

In all this, the value of the voluntary organisations must not be overlooked. In so many instances, our present statutory services had their beginnings in voluntary movements, and still they provide many useful extra facilities, which can be called upon for help and comfort in cases of distress.

Finally it is important that all those involved in the administration of the social services should always keep sight of, and respect, the dignity and integrity of the public they serve. There are countless difficulties of staff shortages, and inadequate premises and financial resources to overcome, but they should not be held up as the reasons for overfull waiting-rooms, disorganised appointment lists, the monotonous passing from one department to another, and so on. A right use of existing personnel and facilities can often eliminate these wearisome suggestions of a petty bureaucracy.

Only by keeping before them the clear vision and high ideals of those who, against discouraging opposition and difficulty, set going the movements that have grown into our modern social services, can present day workers and users hand them on in efficient working order to future generations.